First Health Services Corporation
A Coventry Health Care Company

Document Scanning and Data Correction

VaMMIS Procedure Manual

Version 1.0

June 11, 2008

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	01/09/08	[redacted], Documentation Mgmt. Team	Creation of document

Table of Contents

Preface

The Procedures Manual for the Virginia Medicaid Management Information System (VaMMIS) is a product of First Health Services Corporation. Individual manuals comprise the series of documents developed for the operational areas of the VaMMIS project. Each document includes an introduction, a functional overview of the operations area, workflow diagrams illustrating the processing required to accomplish each task, and descriptions of relevant inputs and outputs. Where appropriate, decision tables, lists, equipment operating instructions, etc. are presented as exhibits, which can be photocopied and posted at unit workstations. Relevant appendices containing information too complex and/or lengthy to be presented within a document section are included at the end of the document.

Use and Maintenance of this Manual

The procedures contained in this manual define day-to-day tasks and activities for the specified operations area(s). These procedures are based on First Health Services' basic MMIS Operating System modified by the specific constraints and requirements of the Virginia MMIS operating environment. They can be used for training as well as a source of reference for resolution of daily problems and issues encountered.

The unit manager is responsible for maintaining the manual such that its contents are current and useful at all times. A hardcopy of the manual is retained in the unit for reference and documentation purposes. The manual is also available on-line for quick reference, and users are encouraged to use the on-line manual. Both management and supervisory staff are responsible for ensuring that all operating personnel adhere to the policies and procedures outlined in this manual.

Manual Revisions

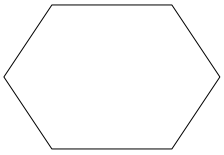
The unit manager and supervisory staff review the manual once each quarter. Review results are recorded on the Manual Review and Update Log maintained in this section of the document. Based on this review, the unit manager and supervisory staff determine what changes, if any, are necessary. The unit manager makes revisions as applicable, and submits them to the Executive Account Manager for review and approval. All changes must be approved by the Executive Account Manager prior to insertion in the manual. When the changes have been approved, the changes are incorporated into the on-line manual. Revised material is noted as such to the left of the affected section of the documentation, and the effective date of the change appears directly below. A hardcopy of the revised pages are inserted into the unit manual, and copies of the revised pages are forwarded to all personnel listed on the Manual Distribution List maintained in this section of the manual.

Flowchart Standards

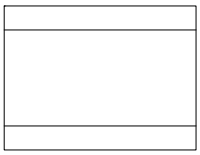
The workflow diagrams included in this document were generated through the flowcharting software product Visio Professional. Descriptions of the basic flowcharting symbols used in the VaMMIS documentation are presented below.

Large Processing Function

Manual Process. No automated processes are used; e.g., clerical function.

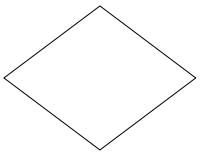


Data Preparation Processing; e.g., mailroom, computer operations, etc.

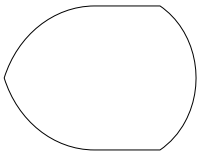


Create a Request

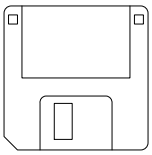
Data maintained in a master datastore.



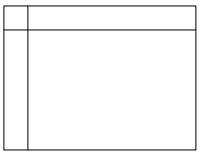
Decision



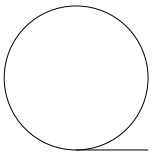
Information entered or displayed on-line.



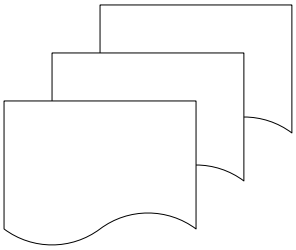
Data stored on diskette media.



On-line Storage; e.g., CD-ROM, microform, imaged data, etc.

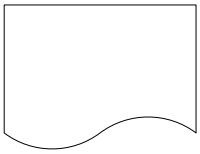


Input or Output Tape



Multiple Outputs; e.g., letters, reports

Communication Link



Single Output; e.g., letter, report, form, etc.

External Entity. Source of entry or exit from a process.

Off-page Connector

1.0 Overview of the Virginia Medical Assistance Program

The Commonwealth of Virginia State Plan under Title XIX of the Social Security Act sets forth the Commonwealth's plan for managing the Virginia Medical Assistance Program (VMAP). It defines and describes the provisions for: administration of Medical Assistance services; covered groups and agencies responsible for eligibility determination; conditions of and requirements for eligibility; the amount, duration, and scope of services; the standards established and methods used for utilization control, the methods and standards for establishing payments, procedures for eligibility appeals; and waivered services.

1.1 Standard Abbreviations for Subsystem Components

For brevity, subsystem components use these abbreviations as part of their nomenclature.

Abbreviation	Subsystem
AM	Automated Mailing
AS	Assessment (Financial Subsystem)
CP	Claims Processing
DA	Drug Application
EP	EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
FN	Financial Subsystem
MC	Managed Care (Financial Subsystem)
MR	MARs (Management and Reporting)
POS	Point of Sale (Drug Application)
PS	Provider
RF	Reference
RS	Recipient
SU	SURS (Surveillance Utilization and Review)
TP	TPL (Financial Subsystem)

1.2 Covered Services

The Virginia Medical Assistance Program covers all services required by Federal legislation and provides certain optional benefits, as well. Services are offered to Medicaid Categorically Needy and Medically Needy clients. In addition, certain services are provided to eligibles of the State and Local Hospitalization (SLH) program and the Indigent Health Care (IHC) Trust Fund. SLH, Temporary Detention Orders (TDO), and IHC are State and locally funded programs with no Federal matching funds. SLH is a program for persons who are poor, but not eligible for Medicaid in Virginia, which is funded by the Commonwealth and local counties.

Services and supplies that are reimbursable under Medicaid include, but are not limited to:

- Inpatient acute hospital
- Outpatient hospital
- Inpatient mental health
- Nursing facility
- Skilled nursing facility (SNF) for patients under 21 years of age
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Hospice
- Physician
- Pharmacy
- Laboratory and X-ray
- Clinic
- Community mental health
- Dental
- Podiatry
- Nurse practitioner
- Nurse midwife
- Optometry
- Home health
- Durable medical equipment (DME)
- Medical supplies
- Medical transportation
- Ambulatory surgical center.

Many of the services provided by DMAS require a co-payment to be paid by the recipient. This payment differs by type of service being billed, according to the State Plan. Payment made to providers is the net of this amount.

General exclusions from the Medicaid Program benefits include all services, which are experimental in nature, cosmetic procedures, acupuncture, autopsy examination, and missed appointments. In addition, there are benefit limitations for specific service categories that must be enforced during payment request processing.

1.3 Waivers and Special Programs

In addition to the standard Medicaid benefit package, the Commonwealth has several Federal waivers in effect which provide additional services not ordinarily covered by Medicaid, as well as special programs for pregnant women and poor children. The programs include:

- **Elderly and Disabled** is a Home and Community Based Care (HCBC) waiver program covering individuals who meet the nursing facility level-of-care criteria and who are at risk for institutionalization. In order to forestall institutional placement, coverage is provided for:
  - Personal Care (implemented 1982)
  - Adult Day Health Care (implemented 1989)
  - Respite Care (implemented 1989)
- **Technology Assisted Waiver for Ventilator Dependent Children** is a HCBC waiver implemented in 1988 to provide in-home care for persons under 21, who are dependent upon technological support and need substantial ongoing nursing care, and would otherwise require hospitalization. The program has since been expanded to provide services to individuals over age 21.
- **Mental Retardation Waiver** includes two HCBC waivers that were implemented in 1991 for the provision of home and community based care to mentally retarded clients. They include an OBRA waiver for persons coming from a nursing facility who would otherwise be placed in an ICF/MR, and a community waiver for persons coming from an ICF/MR or community. The Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) updates the eligibility file for Mental Retardation Waivers.
- **AIDS/HIV Waiver** is a HCBC waiver implemented in 1991 that provides for home and community based care to individuals with AIDS, or who are HIV positive, and at risk for institutionalization.
- **Assisted Living Services** include two levels of payment, regular and intensive. Regular assisted living payments (per day per eligible recipient) are made from state funds. Intensive

assisted living payments (per day per eligible recipient) are covered under an HCBC waiver and are made from a combination of state and federal funds.

- **Adult Care Resident Annual Reassessment and Targeted Case Management** provides for re-authorization and/or follow-up for individuals residing in assisted living facilities. The program includes a short assessment process for individuals who are assessed at the residential level and a full assessment for individuals who are assessed at the regular or intensive assisted living level. The targeted case management is provided to individuals who need assistance with the coordination of services at a level which exceeds that provided by the facility staff.
- **PACE/Pre-PACE Programs** provide coordination and continuity of preventive health services and other medical care, including acute care, long term care and emergency care under a capitated rate.
- **Consumer-Directed Personal Attendant Services** is a HCBC waiver that serves individuals who are in need of a cost-effective alternative to nursing facility placement and who have the cognitive ability to manage their own care and caregiver.
- **MEDALLION Managed Care Waiver** is a primary care physician case management program. Each recipient is assigned a primary care physician who is responsible for managing all patient care, provides primary care, and makes referrals. The primary care physician receives fees for the services provided plus a monthly case management fee per patient.
- **MEDALLION II Managed Care Waiver** is a fully capitated, mandatory managed care program operating in various regions of the State. Recipients choose among participating HMOs, which provide all medical care, with a few exceptions.
- ***Options*** is an alternative to MEDALLION where services are provided through network providers, and the participating HMOs receive a monthly rate based on estimated Medicaid expenditures.
- **Client Medical Management (CMM)** is the recipient "lock-in" program for recipients who have been identified as over utilizing services or otherwise abusing the Program. These recipients may be restricted to specific physicians and pharmacies. A provider who is not the designated physician or pharmacy can be reimbursed for services only in case of an emergency, written referral from the designated physician, or other services not included with CMM restrictions. The need for continued monitoring is reviewed every eighteen (18) months. The services not applicable to CMM are renal dialysis, routine vision care, Baby Care, waivers, mental health services, and prosthetics.
- **Baby Care Program** provides case management, prenatal group patient education, nutrition counseling services, and homemaker services for pregnant women, and care coordination for high risk pregnant women and infants up to age two.

1.4 Eligibility

Medicaid services are to be provided by eligible providers to eligible recipients. Eligible recipients are those who have applied for and have been determined to meet the income and other requirements for the Department of Medical Assistance Services (DMAS) services under Medicaid. Virginia also allows certain Social Security Income (SSI) recipients to "spend down" their income to Medicaid eligibility levels by making periodic payments to providers.

Virginia is a Section 209(b) state, meaning that the DMAS administers Medicaid eligibility for SSI eligibles and State supplement recipients locally through the Department of Social Services (DSS). DSS administers eligibility determination at its local offices and is responsible for determining Medicaid eligibility of Temporary Assistance to Needy Families with Children (TANF), Low-Income Families with Children (LIFC), and the aged. DSS also determines financial eligibility of blind and disabled applicants. In addition, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) administers recipient eligibility for Mental Retardation Waivers. The Department of Visually Handicapped (DVH) and the Department of Rehabilitative Services (DRS) are responsible for determining the degree of blindness of an applicant and the determination of medical necessity, respectively.

Three categories of individuals are eligible for services under the VMAP: Mandatory Categorically Needy, Optionally Categorically Needy, and Optionally Medically Needy. In addition, DMAS operates two other indigent healthcare financing programs, the State and Local Hospitalization (SLH) and the Indigent Health Care (IHC) Trust Fund.

1.5 Eligible Providers and Reimbursement

Qualified providers enroll with the VMAP by executing a participation agreement with the DMAS prior to billing for any services provided to Medicaid eligibles. Providers must adhere to the conditions of participation outlined in the individual provider agreement. To be reimbursed for services, providers must be approved by the Commonwealth and be carried on the Provider Master File in the MMIS.

DMAS employs a variety of reimbursement methodologies for payment of provider services. Inpatient hospital and long-term care facilities are reimbursed on a per diem prospective rate, which goes into effect up to 180 days after the beginning of the rate period to allow for retroactive payment adjustments. Settlement is based on a blend of the per diem rate and the APG/DRG Grouper reimbursement methodology. Other providers are reimbursed on a fee-for-service (FFS) basis according to a Geographic Fee File maximum amount allowed. In the FFS methodology, payment is the allowed amount, or the charge, whichever is less; payment is adjusted by co-payment, as well as by any third-party payment. Medicare co-insurance and

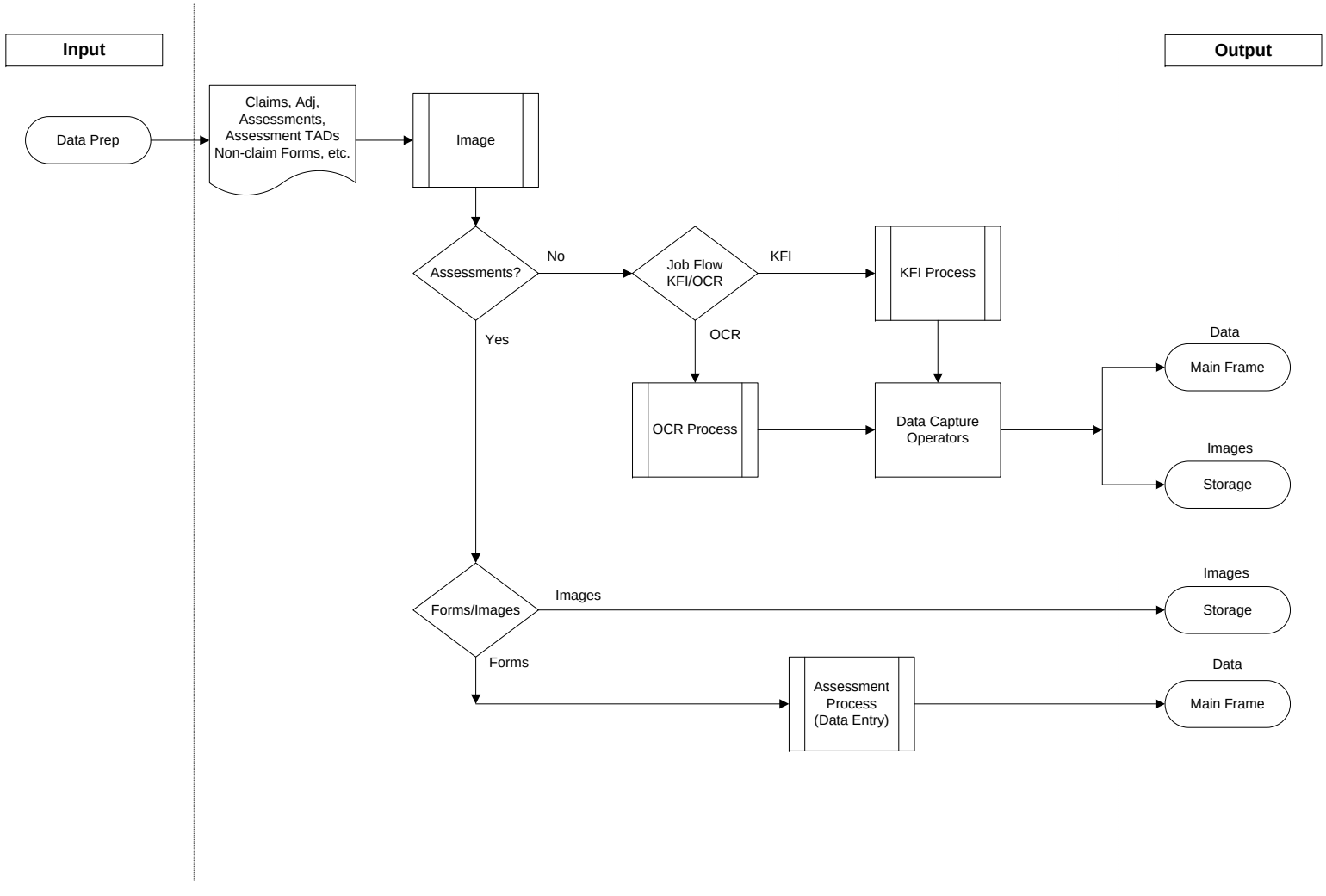
deductibles received in the crossover system are reduced to the Medicaid allowance when the Medicare payment and the Medicaid co-insurance amount would exceed the Medicaid-allowed amount. In addition to these payment methodologies, the MEDALLION managed care program uses case management fees as well as FSS. MEDALLION II is fully capitated and uses a per member, per month, payment methodology. Health maintenance organizations (HMOs) participating in the Options program are paid a monthly rate based on estimated Medicaid expenditures. Monthly fees are also paid for Client Medical Management (CMM).

2.0 Document Scanning and Data Correction

The diagrams on the following pages present a graphic depiction of the document scanning and data correction processes.

WORKFLOW PROCESS

Document Scanning/Data Correction



3.0 Optical Character Recognition (OCR) Workflow

The OCR workflow is performed on HCFA-1500, CMS-1500, and UB-92 Payment requests. It involves using recognition technology to capture data and the Data Capture Operators to enter questionable characters and perform data verification. This process is only used on forms that are printed in red.

All OCR documents are scanned to produce electronic images that are used for retrieval and data capture. The major scanner settings for these documents are as follows:

- Image resolution: 300dpi
- Simplex (one side of page only).

3.1 Scanner Job Names

Scanner job names identify the batch scanning software to be used to scan a group of documents; the number of documents that are to be scanned as a batch and when a separator sheet is required. It also identifes the processing route. Any HCFA-1500, CMS-1500's, or UB-92 claim that requires special batching will also use the following scan job names:

Scan Job Name	Description
HCFAPLUS	HCFA-1500 with attachments
CMS1500PLUS	CMS-1500 with attachments
UB92PLUS	UB-92 with attachments
HCFA	HCFA-1500 without attachments
CMS1500	CMS-1500 singles
UB92	UB-92 without attachments

Procedure

1. At the beginning of each day, the Image Control Number is either entered or verified for correctness at the document scanner.
2. Due to the large volume, HCFA-1500 claims will be scanned first, followed by the UB's. This sequence can be changed at anytime.
3. Once the operator is ready to scan the selected claims, the appropriate scan job is selected.
4. After several batches have been scanned, the operator presses the **Process** button to send these batches to the OCR jobflow process.
5. This process continues until all HCFA-1500 and UB's have been imaged.

6. Payment Requests are staged in the imaging area until Quality has been performed.

List of Scanner Job Names		
Batch Name Prefix	**Scanner Job Name**	**Invoice Type**
HCA	1 HCFA Plus	HCFA-1500 Attachments
HCN	1 HCFA	HCFA-1500 Singles
UBA	1 UB92 Plus	UB-92 Attachments
UBN	1 UB92	UB-92 Singles
HCA	1 HCFA K Plus	HCFA-1500 handwritten Singles
HCN	1 HCFA K	HCFA-1500 handwritten Attachments
UBA	1 UB92 K Plus	UB-92 handwritten Attachments
UBN	1 UB92K	UB-92 handwritten Singles
UXA	2 UX92 Plus	UB/T18 Crossover Attachments
UXN	2 UX92	UB/T18 Crossover Singles
UXA	2 UX92 K Plus	UB/T18 Crossover Handwritten Attachment
UXN	2 UX92 K	UB/T18 Crossover Handwritten Singles
HXA	1:CMS1500 OCR-Plus	HCFA CMS 1500 Attachments
HXN	1: CMS1500 OCR	HCFA CMS 1500 Singles
HXA	1: CMS1500 KEY	HCFA CMS 1500 Handwritten Attachments
HXN	1: CMS1500 KEY-Plus	HCFA CMS 1500 Handwritten Singles

3.2 Start Up the Scanner

To start the scanning operation, the following tasks must be performed.

- Start the scanner machine.
- Log on and start the software program (Capture).

Always follow these rules when using the scanner and scanner program:

- Turn the scanning machine on before turning on the workstation.
- At the end of the work day, choose Exit to close the Capture software program. Wait until the Shutdown message appears before turning the power off.
- Turn off the scanner using the button at the back.

Procedure

1. Turn on the scanning machine.

2. Turn on the attached workstation.
3. Log on using the special logon.
4. Use the special password for the scanner.

   Note: Each scanner has its own logon and password. See the scanner supervisor for these logons/passwords.

5. Double-click on the **Capture Software** icon.
6. Enter the logon and password again. You are ready to scan.
7. To start the **Capture Software** program:
   - ❖ Click on the **Capture** icon on the desktop.
   - ❖ Click on *File*, then *Open Application*s.
   - ❖ Click on the job name you want to open.
   - ❖ Click on *New Batch*.
   - ❖ Check for the correct batch name and number.
   - ❖ Click *OK*.
   - ❖ Click on the green button (*GO*) on the task bar.

On the scanner:

1. Change the Julian date, if necessary.
2. Check the Julian date and reference number.

   Note: The reference number has to be changed when switching between modes 1 and 2.

To change the reference number:

1. Press the **Next** key.
2. Key in the Julian date and the next reference number.
3. Press the **Enter** key.
4. Press the green key (*GO*).

To stop a batch or the scanner:

1. Click on the red button on the task bar

   or

   Press the red key.

To process batches:

1. Click on the **Batch** button on the task bar.
2. Click on *Process All* from the drop menu.
3. Click on *Process*.

3.3 Batch Naming Conventions

The batch name identifies the file names of imaged batches that conform to the following schematic. The scanning software names batches in the following format:

- Batch Name = TTXYYJJJSNNNN.BDF
- TT = Job type
- X = Attachment indicator (A = Attachment, N = No Attachment)
- YY = Two position year
- JJJ = Receive Julian date
- S = Scanner identification number (1 or 3) or Special Indicator Switch (S)
- NNNN = Sequential batch number

Procedure

This process is automated and requires no manual intervention except when processing batches requiring a special indicator.

Special Indicator Batches

1. Change scanner identification number to *S*.
2. Scan invoices.
3. Change scanner identification number back to proper number.

3.4 Image Naming Conventions

As images are created in the scanning process, they are named NNNNNNNN.TIF where NNNNNNNN is a sequential number assigned by the scanning software. In order to avoid duplicate file names, the images associated with a batch will be stored in a subdirectory named like the batch name.

Procedure

This is an automated process that requires no manual intervention.

3.5 Image Control Number

All claims (Appendix A) and attachments are assigned a 14-digit Image Control Number (ICN) for tracking, control and an audit trail reference. As each document is imaged, it is automatically stamped with 12-digits of the ICN because of print restrictions of the document scanner. The 14-digit ICN is composed of a number representing the following:

- CC = Century positions (not printed)
- YY = Unit position of year
- JJJ = Receive Julian date
- M = Media/Scanner identification number
- NNNNNN = Sequential batch number

The ICN is also captured electronically and is included in the image information record within a Batch Definition File (BDF).

Procedure

At the beginning of each day, the Image Control Number is entered or verified for correctness by the Scanner Operator.

Once the ICN has been entered at the document scanner, each claim and its attachments are automatically assigned a sequential Image Control Number.

4.0 Optical Character Recognition (OCR) Jobflow

The OCR jobflow process tracks images through scanning, image preprocessing, recognition steps, and provides additional steps to guarantee the validity of data without direct supervision. It then assigns batches to operators for post-recognition completion. The jobflow also routes batches through the verification process and finally through the export process. The processing of batches through all tasks provides easy management of forms processing.

4.1 Update Batch Control Log

Immediately after a batch has been scanned, the scan software routes each batch to this task, which captures information about each batch as it travels through the system.

Procedure

This is an automated process that adds a record to the batch control table and updates the following fields:

- Receive Date - YYYYJJJ
- Batch Name - NNNNNNNN
- Beginning ICN - YYJJJMNNNNNN
- Ending ICN - YYJJJMNNNNNN

1. Generate The Daily Log Report (Appendix B), which controls totals of documents scanned, from the batch control table by using Microsoft Access.

4.2 Check Batch Definition File (BDF)

This process ensures that a correct Batch Definition File (BDF) enters the Jobflow system and that the Jobflow name is **Claimpak**. Additional integrity checks are also included.

Procedure

This is an automated process that also checks the following:

- ICN for correct length and format
- Syntactically correct batch names
- Syntactically correct image lines, including conformance to the batch-naming schema.

Failure of any of these checks routes the batch to the Administrative Review Queue.

4.3 Form Identification

This is a critical step of the process which determines if each image has red dropout ink or black nondropout ink. It also determines if the document has attachments. With the correct scanner bulb, forms printed with special red dropout ink will lose their template during scanning. Lines, columns, and other boilerplate features drop out on this type of form, leaving only the data behind. These types of forms are good candidates for recognition and are sent to the recognition engine for processing. Black non-dropout ink forms are not good candidates for reliable recognition and are not processed by the Recognition task. Instead, the data from these forms is manually keyed during the Completion process.

Procedure

This is an automated process that also checks the following:

- ICN for correct length and format
- Syntactically correct batch names
- Syntactically correct image lines, including conformance to the batch-naming schema.

If any of these audits fail, the batch is routed to the Administrative Review Queue.

4.4 Check Identification

This step ensures that the BDF file contains proper form ID sequencing for multi-page and attachment processing. When invalid sequences are found, the batch is passed to the Completion – Manual ID task for exception handling. Also sent to the Completion - Manual ID task are batches containing images with a form type of **99**. This form type is assigned to an image if the system is not able to recognize the form as a particular type with a relatively high degree of certainty. This step will also check to make sure that any given batch does not contain both types of documents. If this condition is the only error in the batch, than an entry will be made in the error log and the batch will be routed to the Administrative Review task.

Procedure

This is an automated process that requires no manual intervention.

4.5 Completion - Manual Identification

In this task, operators handle exception claims that have been routed from the Check Identification task. Operators key the correct Form ID numbers that identify sequencing for multi-page claims, claims with attachments or low-confidence form identification parameters. Operators will key in these number codes to identify the forms.

Forms	Codes
HCFA-1500	01 - Red Drop Out forms (Everything in red drops out) 02 - Xerox, internet and problem Red forms (Black lines are displayed) 91 - Attachments
UB-92	03 - Red Drop Out forms (Everything in red drops out) 04 - Xerox, internet and problem Red forms (Black lines are displayed) 91 - Attachments
CMS-1500	01 - Red Drop Out forms (Everything in red drops out) 02 - Xerox, internet and problem Red forms (Black lines are displayed) 91 - Attachments

When done, the claim is then rerouted back to the Check Identification task.

Note: Any batch that comes through Form ID three (3) times has a problem document. To resolve a batch with a problem document, see the Resolve a Problem Batch procedures on the following page

Procedures

To Start the Form ID process:

1. Click on **Form ID** or **Job Flow** in the XXXXX program.
2. You see the **First Health Job Flow** dialog box.
3. Click on the down arrow.
4. Highlight *Auto Claims*.
5. Click under **Task Description**.
6. Highlight *Completion Identify Images*.
7. You see the image to be identified. The window title will be: **First Health Completion - Claim Pak, Job Name and Batch Number**
8. Hold down the right mouse button and move the cursor over the image presented. This is to verify that all the red text has dropped out of a **Red Drop-Out** form.
9. Identify the form as (HCFA-1500, CMS-1500 or UB) and follow the instructions in the table below.

	If	Then
For HCFA-1500 and CMS-1500 forms	If all the background has dropped out (red form)	Key a 1
	A lot or all of the background is still visible	Key a 2

	If	Then
	The form is an attachment	Key a 91
For UB forms	If all the background has dropped out (red form)	Key a 3
	A lot or all of the background is still visible	Key a 4
	The form is an attachment	Key a 91

To Correct a Problem Batch

1. While the document with a problem is still on screen, right-click on the mouse and drag the document over to get the document control number.
2. Click on *View***,** then *BDF data* from the toolbar.
3. In the BDF data, find the document control number. If a **99** is at the beginning of the document control number line, the problem has a deficiency.
4. If the document has a **99**, go back and check the original document and batch.

   Note: If you cannot identify the problem, contact your supervisor.
5. If you can identify the problem with the document, exit and close the **Form ID** program.
6. Click on the **Formware Administrator** icon.
7. Choose *Detail*, then the **Flashlight** icon from the toolbar.
8. Click on the + beside **Files.**
9. Click on the job name.
10. Find the batch with the .BDF extension. Click on it.
11. Find the document number and highlight it.
12. Write down the TIF image number (file name).
13. Press the **Delete** key.
14. Go to the top left-hand corner of the window and delete the *REM=MultiBDF=2* or *3* text.
15. Close the batch by choosing *Yes* from the dialog box.
16. Click on *Job Flow*.
17. Go to **Autoclaims 17** and route the batch you have worked on to Completion - Identify Images.
18. Open the **Form ID** program again. The batch you have just routed will come in and go out after you open the program.
19. Open Windows Explorer.

20. Click on *Apps* in I:Data/Ricnwa01.
21. Click on *Formware* and then click on *Images*.
22. Select the Job Name and the Batch Number.
23. Find the TIF image number (file name).
24. Click on the file name to open and make sure it is the right document.
25. If it is the right document, press the **Delete** key.

4.6 Enhancement

In the Enhancement process, you will modify and adjust images to improve image quality and recognition. Enhancement processing has the ability to perform at the field zone level and is a more form-specific type of image processing. It is designed to perform registration, image cleanup, and dot matrix smoothing tasks.

Procedure

This is an automated process that requires no manual intervention.

4.7 Recognition

The Inscript Recognition Engine is used to capture machine print characters, interpret mark sense areas (check boxes), detect signature presence, and perform field pausing and validation edits. For multi-page forms, validations of total claim charges are performed across all pages of the claim. Batches of images and the associated data derived from the Recognition process are then passed to the next process.

Procedure

This is an automated process that requires no manual intervention.

4.8 Completion - New (Reject Repair)

The Completion process is the Data Entry component of the system. The first pass of the Completion process performs Reject Repair and Key From Image (KFI). Low-confidence characters are presented in queues to Completion operators for repair. Both out-of-context and in-context views display for the operator, resulting in a combination of data entry speed and accuracy. Images for which recognition was not performed are presented to operators as KFI images. Certain field zones for which recognition was not performed are presented to the operator as KFI fields. Field zones are highlighted throughout the image to guide the operator

through the keying process. Field-level edits do not run during this pass of the Completion process.

Procedure

Operators are assigned this task as needed throughout the day by a Supervisor. To open a batch in this Data Capture process, perform the following steps:

1. Double click on **Jobflow** icon.
2. In the menu box under **Jobflow**, select *Autoclaims*.
3. Under **Task Description**, select *Completion-New*.
4. Once a batch is opened, the image of a document is displayed. If the majority of the characters on a claim are recognized, only those characters that are not recognizable will appear at the top of the screen for keying.
5. Continue this process until all documents have been repaired or keyed from Image.

   The batch is closed automatically and the next batch within the queue will appear.

4.9 Rule Client

Comprehensive post-completion edits are performed on the combined data from the recognition engine and the first pass of the Completion process. Because data derived from Reject Repair images have not been validated at this point, forms processed by the recognition engine can still contain invalid data and therefore can benefit from the post-completion edits performed by the Rule Client process. This step of the system runs the same complex set of edits run by the Recognition process. Any fields that fail this process are flagged for review in the next Jobflow step.

Procedure

This is an automated process that requires no manual intervention.

4.10 Completion - Remove Flags

The Completion process is run again in the Remove Flags mode. This allows experienced operators to review data that has failed validation and make the necessary corrections. Field edits are invoked during this step to reduce the risk of introducing any new errors. For multi-page claims, only the detail area and total charges fields are entered for the second and subsequent pages of a claim. Batches pass from the Remove Flags process to the Verify process.

Note: A batch can fail multiple times in the Remove Flags process before moving to the verify process.

Procedure

Operators are assigned this task as needed throughout the day by a supervisor. To open a batch in this Data Capture process, perform the following steps:

1. Double click on the **Jobflow** icon.
2. In the menu box under **Jobflow**, select *Autoclaims*.
3. Under **Task Description**, select *Completion-Remove Flags*.
4. Once a batch is opened, the first image that has an error is displayed and the cursor is positioned on the first flagged field, which is enclosed in a red box. Check the validity of the data by comparing what is displayed on the image to the data that is enclosed in the red box.
    - ❖ If the data is correct, depress the **Shift+Enter** keys or the **]** (bracket) key to accept the data.
    - ❖ If the data is not correct, enter the correct data.
5. Continue this process until all flagged fields have been corrected within a given batch.

   The batch is closed automatically and the next batch in the queue appears.

3.11 Completion – Verify

During the Verify process, completion operators fields and the data is compared to the existing data on a character-by-character basis. Operators receive error messages when comparisons fail, and they are forced to either or correct the data prior to proceeding to the next field. Edits are run during this step in the same manner they ran during the Remove Flags process.

Procedure

This task is assigned as needed throughout the day by a supervisor.

1. To open a batch in this Data Capture process, perform the following:
    - ❖ Double click on the **Jobflow** icon.
    - ❖ In the menu box under **Jobflow**, select *Autoclaims*.
    - ❖ Under **Task Description**, select *Completion-Verify*.
    - ❖ Once a batch is opened, an image of a document is displayed. As data fields are being verified, existing data is compared on a character to character basis. If the

character doesn't compare with what already exists, an error message will appear. You have the option of displaying what was previously keyed by depressing the **F3+W** keys. If data is incorrect, depress the **Del** key to correct the character or the entire field.

2. Continue this process until all records within the batch have been verified.

   The batch is closed automatically and the next batch within the queue is displayed.

4.12 Batch Level Validations

Batch-level validations are performed against the data in each batch. Errors encountered will be logged to the Error Log. Batches that fail a data validity test are routed to the Administrative Review queue.

Procedure

This is an automated process that requires no manual intervention. The following validations are performed in this task:

- Checks for rejected images
- Checks for flags
- Checks for invalid bill types.

4.13 Export Transaction Data

Once the data is ready to export, batches are routed to this task. This task causes the transaction data to be added to a flat ASCII file that is uploaded to mainframe.

During the export process, statistical data is captured. An MS Access database will be updated with each export. At the end of the day, a report is generated that lists the record and document counts of each job type.

Procedure

As batches are completed, they are automatically routed to the export queue. The Imaging Technician monitors this queue and decides when to export to mainframe. Perform the following steps to export batches throughout the day:

1. Double click on the **Jobflow** icon.
2. Open the **Jobflow** folder.
3. Go to the toolbar and select the **Flashlight** icon and *Details* to display all the contents of Jobflow.

4. Click on the **Jobflow Client** icon.
5. You see the **Jobflow** window.
6. Select *Autoclaims* from the menu box under **Jobflow**.
7. Under **Task Description,** select *Export Transaction Data*.
8. Click on *OK*.
9. Choose *Cancel* when a message appears on the screen indicating that no batches are currently awaiting processing. You will return to the **Jobflow** screen.

4.14 Make an Index File

The [redacted] (Document Archive and Retrieval System requires indexed data elements to identify images that are being stored. This tool automatically cretes the indexes using information form data records and the scanner.

Procedure

This is an automated process that requires no manual intervention.

4.15 Merge Overlay

A standard pre-selected form is merged over each image of a red form.

Procedure

This is an automated process that requires no manual intervention.

4.16 Image Export

This task performs the following:

- Puts images in multi-page .TIF format
- Exports images and index data for use by down-stream image management system.

Procedure

This is an automated process that requires no manual intervention.

4.17 Cleanup

Cleanup is an automated process following Export that deletes unneeded files after data is exported. Images, recognition results, and data files are removed from the production environment. By deleting unnecessary files once the transfer of the exported data is confirmed,

the production environment is optimized, allowing it to run efficiently and achieve the high throughput expected from the system.

Procedure

This is an automated process that requires no manual intervention. The following types of files are deleted during this task:

- Image enhancement files (ENH)
- Recognition results files (OCR)

4.18 Archive Management

Batch data and its associated Batch Definition File is automatically moved to an Archive subdirectory by date received. Associated images remain in the production image file. Immediately after the Export task, the Cleanup task automatically scans the Archive subdirectories that are least 14 calendar days old. Archive subdirectories that are over 14 days old are purged. The purge step results in the deletion of the batch data and related batch definition files. In addition, all associated images and their related subdirectories are deleted from the data capture system.

Procedure

This must be done from Jobflow Monitor #9.

1. Double-click on the **Administration** icon.
2. Select the **Files** folder.
3. Click on the **Flashlight** icon.
4. Highlight the *ARCHIVE.bdf* file.
5. Right-click on the mouse.
6. Choose *Send to*, then choose *Execute VBA Application.*
7. You see a window open. Highlight ARCHIVEMANAGEMENT.VBP
8. Choose *Open*.
9. You see a list of files open in another window. Chose *ARCHIVE.TXT*
10. Choose *Open*.
11. When the windows disappear, the archiving is complete.

4.19 Administrative Review

Batches with exception conditions are routed to this queue.

Procedure

The Supervisor resolves items in the administrative review queue.

1. View the queue by using the jobflow maintenance facility.
2. Consult the error log file.
3. Determine exception and take corrective action.
4. Manually re-route to the appropriate queue to continue processing.

5.0 Key From Image (KFI) Workflow

All non-OCR documents are captured using FormWare's Key From Image capability. Forms that only require imaging, such as Assessments also use this workflow.

All KFI and imaged-only documents are scanned to produce electronic images that are used for retrieval and data capture. The major scanner settings for these documents are:

- Image resolution: 200dpi
- Simplex (one side of page only)
- Duplex (both sides).

5.1 Scanner Job Names

Scanner job names identify the batch scanning software to be used to scan a group of documents; the number of documents that are to be scanned as a batch; and when a separator sheet is required. It also identifies the routing process. Any non-HCFA or non-UB claims that require special batching will also use these scan job names:

List of Scanner Job Names		
Batch Name Prefix	**Scanner Job Name**	**Invoice Type**
HXA	1 CMS 1500 OCR-PLUS	HCFA CMS 1500 Typed Attachments
HXN	1 CMS 1500OCR	HCFA CMS 1500 Typed Singles
HXA	1 CMS 1500 KEY-PLUS	HCFA CMS 1500 Handwritten Singles
U4A	1 UB04 OCR-PLUS	UB04 Typed Attachments
U4N	1 UB04 OCR	UB04 Typed Singles
U4A	1 UB04 KEY-PLUS	UB04 Handwritten Attachments
U4N	1 UB04 KEY	UB04 Handwritten Singles
UCA	2 UB04 OCR CROSSOVER-PLUS	UB04 Typed Crossover Attachments
UCN	2 UB04 OCR CROSSOVER	UB04 Typed Crossover Singles
UCA	2 UB04 KEY CROSSOVER-PLUS	UB04 Handwritten Crossover Attachments
UCN	2 UB04 KEY CROSSOVER	UB04 Handwritten Crossover Singles
TXA	3 TI8 PLUS	Title 18s – Attachments
TXN	3 TI8	Title 18s – Singles
VXA	4 T18 VA PLUS	Title 18s – Adjustments/Voids Attachments
VXN	4 T18 VA	Title 18s – Adjustments/Voids Singles

List of Scanner Job Names		
Batch Name Prefix	**Scanner Job Name**	**Invoice Type**
ACA	5 ACA PLUS	Claim Attachment Form
LTA	6 LTC PLUS	Long-Term Care – Attachments
XMA	7 XIMAGE PLUS	Documents (not payment requests) for image retrieval - Attachments
FHA	7 FHINDEX PLUS	Rescan Documents – previously scanned – Attachments
FHN	7 FHINDEX	Rescan Documents – previously scanned – Singles
DAA	8 ADA PLUS	Dental – ADA1994, 1999-2000, 2002 – Attachments
DAN	8 ADA	Dental – ADA1994, 1999-2000, 2002 – Singles
PHA	8 PHARMACY PLUS	Pharmacy – Attachments
PHN	8 PHARMACY	Pharmacy – Singles
PCA	8 COMPOUND PHARMACY PLUS	Compound Pharmacy – Attachments
PCN	8 COMPOUND PHARMACY	Compound Pharmacy – Singles
TTA	9 T18 TDO PLUS	Title 18 TDO or ECO Attachments
TTN	9 T18 TDO	Title 18 TDO or ECO Singles
VTA	9 T18VA TDO PLUS	Title 18 Adj./Voids TDO or ECO Attachments
VTN	9 T18VA TDO	Title 18 Adj./Voids TDO or ECO Singles
HTA	9 CMA 1500 TDO PLUS	HCFA CMS 1500 TOD or ECO Attachments
HTN	9 CMS 1500 TDO	HCFA CMS 1500 TOD or ECO Singles
UTA	9 UB04 TDO PLUS	UB04 TDO Attachments
UTN	9 UB04 TDO	UB04 TDO Singles
UEA	9 UB04 ECO PLUS	UB04 ECO Attachments
UEN	9 UB04 ECO	UB04 ECO Singles
* Regular UB04 Crossover Scanner Job Name can be used for UB04 Crossover TDO or ECO.		

Procedure

1. At the beginning of each day, either key or verify the Image Control Number for correctness at the document scanner.
2. Scan the Prior Review and Authorization Request documents first, followed by Title 18s, Pharmacy, Dental ADA, ACNs, Assessments and Miscellaneous forms. Scan claims that

require Special Batching as they are received. Scan Special Indicator Batches at the end of the day. This sequence can be changed at anytime. Sample forms are in Appendix A.

- ❖ When ready to scan the selected type of work, select the appropriate scan job.

3. After several batches have been scanned, depress the **Process** button to send that set of batches to the KFI jobflow process.
4. Continue this process until all claims have been imaged.
5. Stage Payment Requests in the Imaging area until Quality Checks are performed.

5.2 Start Up the Scanner and Scanning Program

To start the scanning operation, the following tasks must be performed

- Start the scanner machine.
- Log on and start the software program (Capture).

Always follow these rules when using the scanner and scanner program:

- Always turn on the scanning machine first, before turning on the workstation.
- At the end of the work day, choose exit to close the Capture software program. Wait until the Shutdown message appears before turning the power off.

Turn off the scanner using the button at the back.

Procedures

To start the scanner:

1. Turn on the scanning machine.
2. Turn on the attached workstation.
3. Log on using the special logon for each scanner.
4. Use the special password for the scanner.

   Note: Each scanner has its own logon and password. See the scanner supervisor for these logons/passwords.

5. Double-click on the **Capture Software** icon.
6. Enter the logon and password again.
7. You are ready to scan.

To start the Capture software program:

1. Click on the **Capture** icon on the desktop.
2. Click on *File*, the *Open Applications*.
3. Click on the job name you want to open.
4. Click on *New Batch*.
5. Check for the correct batch name and number.
    a. Click *OK*.
6. Click on the green button on the task bar.

On the scanner:

1. Change the Julian date if necessary.
2. Check the Julian date and reference number.

Note: The reference number has to be changed when switching between modes 1 and 2.

To change the reference number:

1. Press the **Next** key.
2. Key in the Julian date and the next reference number.
3. Press the **Enter** key.
4. Press the green (GO) key.
5. Click on the green button on the task bar.

To STOP a batch or the scanner:

1. Click on the red button on the task bar or press the red key.

To process batches:

1. Click on the **Batch** button on the task bar.
2. Click on *Process All* from the drop menu.
3. Click on *Process*.

5.3 Batch Naming Conventions

The batch name identifies the file names of imaged batches. The scan software names batches in the following format:

- Batch Name = TTXYYJJJSNNNN.BDF

- TT = Job type
- X = Attachment indicator (A = Attachment, N = No Attachment)
- YY = Two position year
- JJJ = Receive Julian date
- S = Scanner identification number (1 or 3) or Special Indicator Switch (S)
- NNNN = Sequential batch number

Procedures

This process is automated and requires no manual intervention except when processing batches requiring a special indicator.

Special Indicator Batches

1. Change scanner identification number to *S*.
2. Scan invoices.
3. Change scanner identification number back to proper number.

5.4 Image Naming Conventions

As images are created in the scanning process, they are named NNNNNNNN.TIF where NNNNNNNN is a sequential number assigned by the scanning software. In order to avoid duplicate file names, the images associated with a batch will be stored in a subdirectory named like the batch name.

Procedure

This is an automated process that requires no manual intervention.

5.5. Image Control Number

All claims and attachments are assigned an Image Control Number (ICN) for tracking, control, and an audit trail reference. As each document is imaged, it is automatically stamped with 12 digits of the ICN because of print restrictions of the document scanner. The 14-digit ICN is composed of a number representing the following:

- CC = Century positions (not printed)
- YY = Unit position of year
- JJJ = Receive Julian date
- M = Media/Scanner identification number

- NNNNNN = Sequential batch number

The ICN is also captured electronically and is included in the image information record within a Batch Definition File (BDF).

Procedure

At the beginning of each day, the Scanner Operator either enters the Image Control Number or verifies the ICN for correctness.

Once the ICN has been entered at the Document scanner, each claim and its attachments are automatically assigned a sequential Image Control Number.

6.0 Key from Image (KFI) Jobflow

The KFI Jobflow process tracks images through scanning, image preprocessing, and provides additional steps to guarantee the validity of data without direct supervision. It then assigns batches to operators for completion. The jobflow also routes batches through the verification process and finally through the export process. The processing of batches through all tasks provides easy management of forms processing.

6.1 Update Batch Control Log

Immediately after a batch has been scanned, the scan software routes each batch to this task, which captures information about each batch as it travels through the system.

Procedure

This is an automated process that adds a record to the batch control table and updates the following fields:

- Receive Date - YYYYJJJ
- Batch Name - NNNNNNNN
- Beginning ICN - YYJJJMNNNNNN
- Ending ICN - YYJJJMNNNNNN

1. Generate the **Daily Log Report** (Appendix - B), which controls totals of documents scanned, from the batch control table by using **Microsoft Access**.

6.2 Completion New - Key From Image (KFI)

The Completion KFI process is the Data Entry component of the system that allows manual keying of information from the image. During KFI, Data Entry field zones are highlighted to guide the operator through the keying process along with field level edits being performed.

Procedure

Operators are assigned this task as needed throughout the day by a Supervisor. To open a batch in this Data Entry process, perform the following steps:

1. Double click on the **Jobflow** icon.
2. In the menu box under **Jobflow**, select *KFIJOB*.
3. Under **Task Description**, select *Completion New*.

4. Once a batch is opened, an image of a document is displayed. Key the information in each field that corresponds to the highlighted field zone.
5. Continue this process until all records within the batch have been entered.

   The batch is closed automatically and the next batch within the queue is displayed.

6.3 Completion - Key from Image (KFI) Remove Flags

The completion process is run again in the "Remove Flags" mode. This mode allows experienced operators a chance to review the date that has failed validation and make the necessary corrections. During this process, field edits are invoked to reduce the risk of introducing any new errors.

Note: The same batch might come back to KFI Remove Flags more than once to verify all corrections that were made the first time.

Procedure

Operators are assigned this task as needed throughout the day by a Supervisor. To open a batch in this Data Entry process, perform the following steps:

1. Double click on the **Jobflow** icon.
2. In the menu box under **Jobflow**, select *KFIJOB*.
3. Under **Task Description**, select *Completion-Remove Flags*.
4. Once a batch is opened, the first image that has an error is displayed and the cursor is positioned on the first flagged field. The contents of the flagged field are enclosed in a red box. Check the validity of the data by comparing what is displayed in the image to the data that is in the red box.
   - ❖ If the data is correct, hold down the **Shift+Enter** keys or the **]** (bracket) key to
   - ❖ Accept the data as presented.
   - ❖ If the data is not correct, enter the correct data.
5. Continue this process until all flagged fields within the batch have been corrected.

   The batch is closed automatically and the next batch within the queue is displayed.

6.4 Batch Level Validations

Batch-level validations are performed against the data in each batch. Errors encountered will be logged to the Error Log. Batches that fail a data validity test are routed to the Administrative Review queue.

Procedure

This is an automated process that requires no manual intervention. The following validations are performed:

- Checks for rejected images
- Checks for flags
- Checks for invalid bill types.

6.5 Export Transaction Data

Once the data is ready to export, batches are routed to this task. This task, causes the transaction data to be added to a flat ASCII file that is uploaded to the mainframe.

During the Export process, statistical data is captured. An MS Access database is updated with each export. At the end of the day, a report is generated that lists record and document counts for each job type.

Procedure

As batches are completed, they are automatically routed to the export queue. The Imaging Technician monitors this queue and decides when to export to mainframe. Export batches throughout the day by performing the following steps:

1. Double click on the **Jobflow** icon.
2. Open the **Jobflow** folder.
3. Go to the toolbar and select **Flashlight** and *Details* to display all the contents of Jobflow.
4. In the menu box under **Jobflow**, select *KFIJOB.*
5. Under **Task Description**, select *Export Transaction Data*.
6. Click on *OK*.
7. Choose *Cancel* when a message appears on the screen indicating that no batches are currently awaiting processing. You will be returned to the **Jobflow** screen.

6.6 Make an Index File

The [redacted] (Document Archive and Retrieval System requires indexed data elements to identify images that are being stored. This tool automatically cretes the indexes using information form data records and the scanner.

Procedure

This is an automated process that requires no manual intervention.

6.7 Image Export

This tasks performs the following:

- Puts images in multi-page TIFF format
- Exports images and index data for use by down-stream image management system.

Procedure

This is an automated process that requires no manual intervention.

6.8 Cleanup

Cleanup is an automated process following Export that deletes unneeded files after data is exported. Images, recognition results, and data files are removed from the production environment. By deleting unnecessary files once the transfer of the exported data is confirmed, the production environment is optimized allowing it to run efficiently and achieve the high throughput expected from the system.

Procedure

This is an automated process that requires no manual intervention. The following types of files are deleted during this task:

- Image enhancement files (ENH)
- Recognition results files (OCR).

6.9 Archive Management

Batch data, and its associated Batch Definition File, is automatically moved to an Archive subdirectory by date received. Associated images remain in the production image file. Immediately after the Export task, the Cleanup task automatically scans the Archive subdirectories that are at least 14 calendar days old. Archive subdirectories that are over 14 days old are purged. The purge step results in the deletion of the batch data and related batch definition files. In addition, all associated images and their related subdirectories are deleted from the data capture system.

Procedure

This must be done from Jobflow Monitor #9.

1. Double-click on the **Administration** icon.
2. Select the **Files** folder.
3. Click on the **Flashlight** icon.
4. Highlight the *ARCHIVE.bdf* file.
5. Right-click on the mouse.
6. Choose *Send to*, then choose *Execute VBA Application*.
7. You see a window open. Highlight *ARCHIVEMANAGEMENT.VBP*
8. Choose *Open*.
9. You see a list of files open in another window. Chose *ARCHIVE.TXT*
10. Choose *Open*.
11. When the windows disappear, the archiving is complete.

6.10 Administrative Review

Batches with exception conditions are routed to this queue.

Procedure

The Supervisor resolves items in the administrative review queue.

1. View the queue by using the jobflow maintenance facility.
2. Consult the **Error Log** file.
3. Determine exception and take corrective action.
4. Manually re-route to appropriate queue to continue processing.

7.0 Failed Image Index Resolution

When an image file is loaded into the [redacted] system, it updates the database with the index data that was provided and stores the indexed batch into archive storage. There are occasions when this process fails to load image indexes into storage. The procedures in this section contain the process for failed image index recognition and resolution.

7.1 [redacted] Image Index Format Task

[redacted] uses index fields to locate records in the database that meet the search criteria entered by the user. The index record contains the physical location of an item on a storage volume. And allows more efficient access to documents by creating a direct path to a document through pointers.

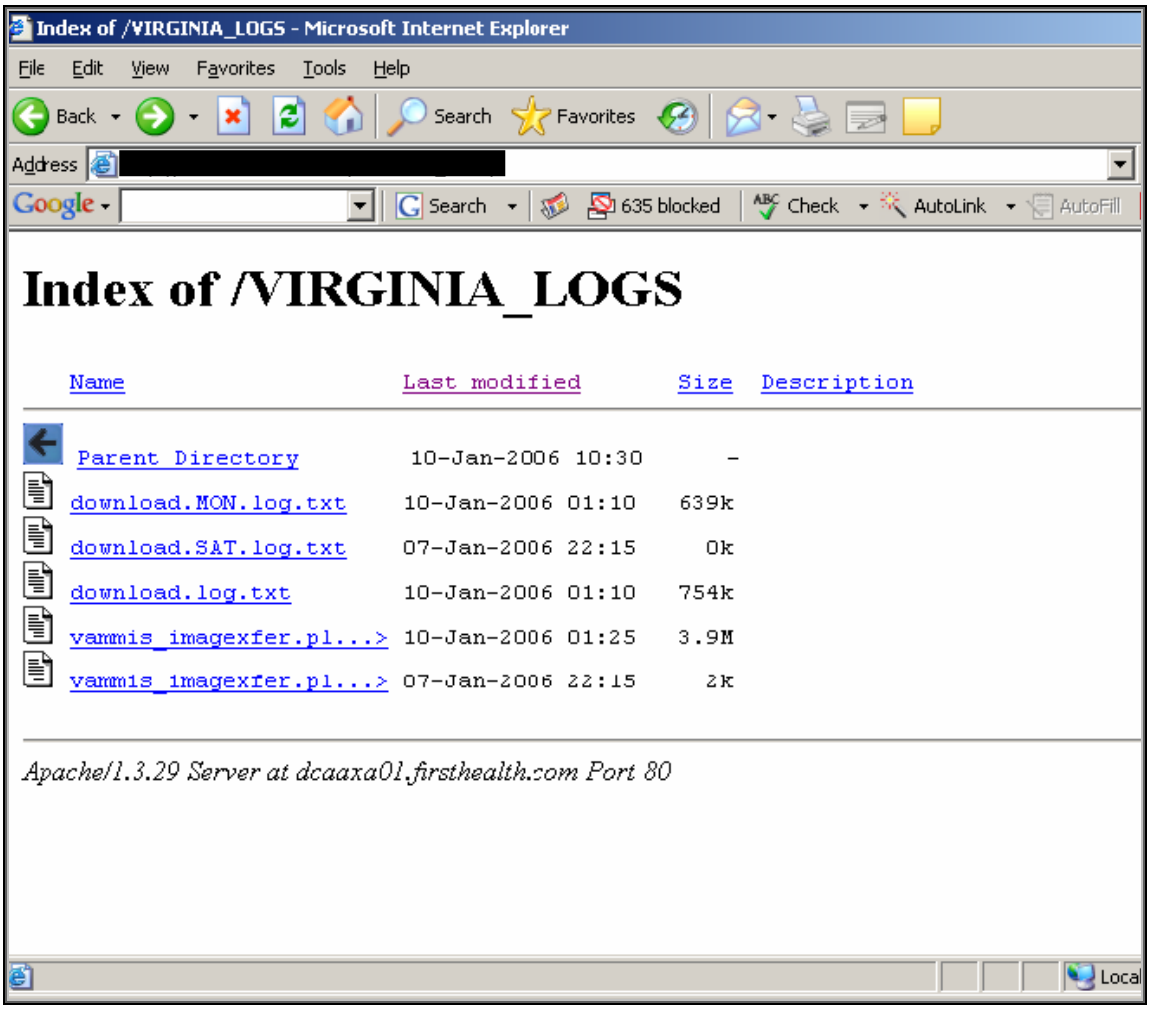
Example
Field Names Begin:
DCN
State_Code
Recipient_ID
Provider_ID
Field Names End:
052660161001
VA
0600367415
OP0095
052660161001.tif
0
0
052660161002
VA
0600180378
PO3834
052660161002.tif
0
0

7.2 Identifying Failed Images

A failed image index is defined as an index that fails to properly load to the [redacted] server from the local server. A single failed image on an index will prevent the entire index from loading, and any one index can contain as many as 100 images. All failed image information is contained on the Load Log Report and in the Failed Image Report(or the No Load List) generated by the Richmond First Health Service office.

Procedure

1. Images (.TIFS) that have failed the import process are errors and can be found:
   - ❖ In the [redacted] error logs, found at [redacted], when research on a particular day's activity is needed.
   - ❖ The **Failed Image Report** is a comprehensive report that includes all failed images from any period of time, which have not been resolved. See Example 1.
2. Load logs are replaced weekly with the week's current log. Old load logs can be found at [redacted]. See Example 2.

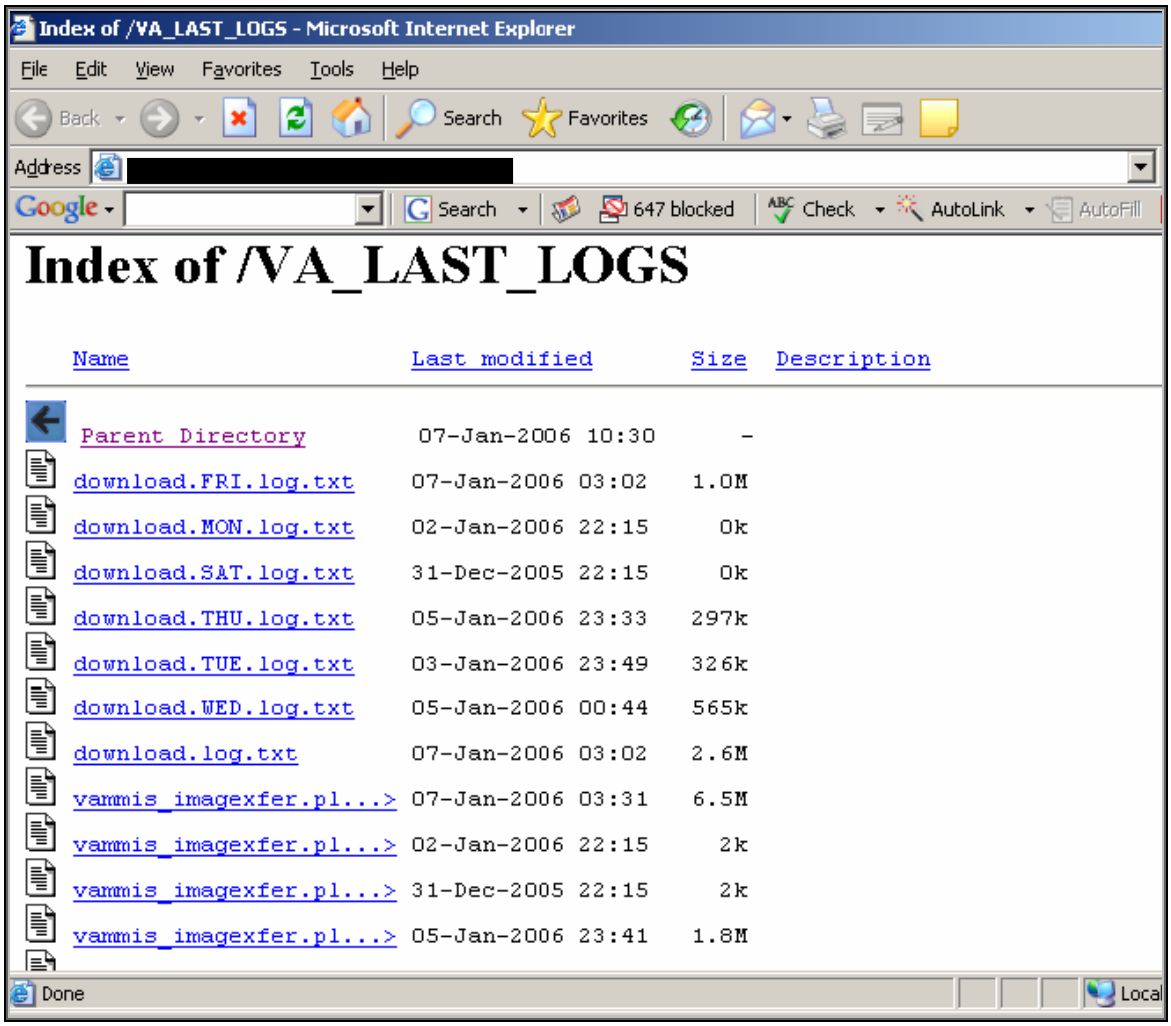


Example 1 - A. Load Logs

Summary section of the image load log:

```
  Statistics for this run:
            Start time:                          03:47
            Stop time:                           03:59
            Index files present:                 374
            Index files ready:                   374
            Image files requested:               5765
            Image files ready in index files:    5391
  ERROR:W:Image_files_orphaned_after_loads:      2102
            OnDemand arsload OK:                 374
            Index files downloaded:              374
            Image FTP attempts:                  5391
            Image FTP good:                      5391


FILE(s) NOT LOADED AS OF Tue Jan 10 11:30:07 EST 2006

Base Directory = /home/arsload/images/imsexport

Orphaned Tif files:

Total: 0 Bad Index files

Total: 0 Orphaned Tif files
```

Example 1 - B. Failed Image Report



Example 2

7.3. Method 1 – Resolving Failed Images Using the Load Log Report

Several errors can occur that will prevent an image from loading to [redacted]. Errors can be generated by the following error types:

A. ARSLOAD Errors

B. Other Errors:

1. ERROR:E:TIF_MISSING:hcn 052590166080.tif
2. ERROR:W:Bad_index_file_hcn042220158.ind: # of tiffs needed. # of tiffs found.
3. ERROR:W:Index_files_not_ready: # of index files
4. ERROR:A:Image_files_not_present: # of index files

5. ERROR:A:ARSLOAD_Failure:[1] [/arsload/mnt/VA/imsexport/hcn/hcn0501220323]
6. ERROR:E:[redacted]_arsload_FAILED: # of image files
7. ERROR:W:Image_files_orphaned_after_loads: # of image files
8. ERROR:F:ARSFTP_Cannot_connect:$@
9. ERROR:F:ARSFTP_Cannot_login:$ftp->message
10. ERROR:F:ARSFTP_cannot_access_$nwpath
11. ERROR:W:FTP_Download_Error:HCN/052450159043.tif [58072] [0] ERROR:W:Image FTP failed: # of image files

Procedures

A ARSLOAD Error

1. To start problem determination, open the **System Log** folder and view the messages that the **ARSLOAD** program generated during the load process. The message log will contain normal processing messages, return codes, and error messages.
2. If the **ARSLOAD** program failed during indexing, correct the problem and then restart the load process from the beginning.

   Common causes of problems during indexing include:

   - ❖ Invalid input files or indexing parameter files, and
   - ❖ Insufficient temporary space.
3. If the **ARSLOAD** program failed during database processing or storage manager processing. Determine and correct the problem.
4. If a **Load ID** is listed in the message log that the **ARSLOAD** program saved in the system log, then you can use the **ARSADMIN** program to unload the data.

B Other Errors:

Error Resolution

To start problem determination, open the Processing log (e.g. VA_imagexfer.pl.0600.WED.log.tx) for a specific cycle and view the messages generated during the transfer and load process.

B.1 Image file listed in index file was not available or missing.

- ❖ Possible causes:
  - – Image file was not old enough to transfer at transfer time.

- Image file could not transfer cleanly at transfer time and was left on the server for a later transfer.
- Image file was not in [redacted] imaging cluster.

❖ Error Type(s):

- ERROR:E:TIF_MISSING:hcn 052590166080.tif
- ERROR:W:Bad_index_file_hcn042220158.ind: # of tiffs needed. # of tifs found.
- ERROR:W:Index_files_not_ready: # of index files
  ERROR:A:Image_files_not_present: # of index files

❖ Procedures for Resolution:

- Make sure the image file is on the [redacted] imaging cluster so it will be transferred on the next cycle.
- Otherwise, generate a new index file without the indexes for that image file so the rest of the images can load.

B.2 The attempted load of a batch into [redacted] failed.

❖ Possible causes:

- Improperly formed index file.
- Error with [redacted] applications, such as server processes not responding.

❖ Error Type(s):

- ERROR:A:ARSLOAD_Failure:[1] [/arsload/mnt/VA/imsexport/hcn/hcn0501220323]
- ERROR:E:[redacted]_arsload_FAILED: # of index files

❖ Procedures for Resolution:

- Check the error messages associated with the batch load.
- If there is a problem with an index value, correct the index file and put it on the [redacted] imaging cluster for the next transfer.
- Otherwise, submit a Help Desk ticket for the [redacted] team to research.

B.3 All of the index files have been processed and some image files remain on the [redacted] server.

❖ Possible causes:

- Batch was aborted in [redacted] imaging cluster, but images were left behind.

- A file that did not transfer cleanly with its index file finally transferred cleanly. The index file was already processed.

❖ Error Type(s):

- ERROR:W:Image_files_orphaned_after_loads: # of image files

❖ Procedures for Resolution:

- Re-create the index file for the images and put it on the [redacted] imaging cluster for the next transfer.

B.4 Transfer script was unable to communicate properly with the [redacted] server.

❖ Possible causes:

- Network down
- Netware server down
- Configuration change on Netware server

❖ Error Type(s):

- ERROR:F:ARSFTP_Cannot_connect:$@

❖ Procedures for Resolution:

- Submit a Help Desk ticket.

B.5 Transfer script was unable to log into the [redacted] Netware server.

❖ Possible causes:

- Transfer account on [redacted] Netware server has been disabled
- Transfer account on [redacted] Network server has had password changed.

❖ Error Type(s):

- ERROR:F:ARSFTP _Cannot _login:$ftp->message

❖ Procedures for Resolution:

- Submit a Help Desk ticket.

B.6 Transfer account was unable to change directory to where the images are stored.

❖ Possible causes:

- Rights to images directory have changed.
- Configuration of images directory has changed to be incompatible with UNIX.
- Images directory has been moved, renamed, or deleted.

❖ Error Type(s):

- ERROR:F:ARSFTP_cannot_access_$nwpath

❖ Procedures for Resolution:

- Submit a Help Desk ticket

B.7 File was not the same size after it was transferred as it was before the transfer.

❖ Possible causes:

- TCP error on the LAN caused TCP/IP packet to become corrupted.
- Image was modified on [redacted] Netware server during transfer.
- [redacted] Server has run out of disk space.

❖ Error Type():

- ERROR:W:FTP_Download_Error:HCN/052450159043.tif [58072] [0]
- ERROR:W:Image FTP failed: # of image files

❖ Procedures for Resolution:

- If there are multiple download errors, submit a Help Desk ticket.
- If the file is still on the [redacted] Server, let the next transfer activity process the file.
- If the error repeats for the same file, replace the file on the [redacted] Server.

7.4 Method II – Resolving Failed Images Using the Daily Control Log

Several errors can occur that will prevent an image from loading to [redacted]. Errors can be generated by the following sources:

1. Virginia Data Capture Unit
2. [redacted], performing data entry for the overflow of CMS 1500 claims.
3. [redacted].

Procedures

When an image index fails to import correctly ([redacted]), the problem has to be researched and corrected by the proper source before the image will [redacted]. Daily Control Logs identify Batch Names, ICN Ranges and the source of Data Capture. Use the Batch Name or ICN to determine the source that is responsible for correcting the problem.

Source 1 - Virginia Data Capture Unit:

1. Identify the batch name that the problem .TIF is in.
    - ❖ Pull the **Daily Control Log** and locate the batch name that the problem .TIF is in.
    - ❖ Write the batch name down to use for research.
2. Check batch for the following errors:
    - ❖ An attachment identified as a form to be keyed opposed to an actual attachment.
        - – Delete the attachment from the batch by selecting *Form/Delete* from the toolbar area then skip to #3.
    - ❖ Batch contains duplicate ICN numbers.
        - – Page down thru the batch to locate documents with the same ICN.
        - – Delete one of the duplicates then skip to #3.
    - ❖ All other problems should be addressed with the support team at [redacted]
3. Delete the batch name with the extension of .IMG located in the Image folder of the batch to be fixed.
    - ❖ Open the **IMAGE** folder from Explore
    - ❖ Open the folder of the claim type to be fixed
    - ❖ Double click on the batch name
    - ❖ Go to the end of the listed TIFS and highlight the batch name with the .IMG extension and click *Delete*.
4. Create a new .IND for the batch that is being corrected. (This function must be done on monitor #9 because the software that performs this task is only on #9.)
    - ❖ In Administration, open the file folder of the batch name for which the .IND is needed
    - ❖ Click the **Flashlight** icon in the toolbar section.
    - ❖ Highlight the batch name (without the .BDF extension)
    - ❖ Go to the **Toolbar** section and choose *Process*, then *Batch Processing*, then *Edit*.
    - ❖ In the **Program Name** area, type in *EXECVBA* and click *OK*.
5. Route BDF to Edits Image Export Folder. (This process resends the corrected image to DARS)
    - ❖ In Formware Administration, open the **Files** folder

- ❖ Open the job name of the batch to be routed
- ❖ Highlight the BDF (Batch with the .BDF extension)
- ❖ From the toolbar section select *Process*, then select *Jobflow*, then select *Autoclaims*, then select *Edits Image Export*, then select *OK*

6. Verify images are stored on [redacted].

- The day after the images have been corrected and exported to [redacted], search for the range of ICN's that were corrected. If the images are displayed, the problem has been fixed and no other action is required.
- If the images failed to load, open a ticket with the FHSC helpdesk for assistance from the [redacted] team.

Source 2 - Problem Is Usually With The Index Data Which Was Keyed/Captured

1. Notify the vendor
   - ❖ Give them the problem .TIF and the Batch Name
   - ❖ Vendor will research the problem and e-mail the corrected Index data back to the Image Tech.
   - ❖ Save the IND to the IMSTEMP folder
   - ❖ Open e-mail
   - ❖ From the **Toolbar** section, select *File*, then *SaveAs*, then *Highlight Attachment*, then *Browse*, then *APPSon I*, then *Newsys, then I mstemp*, then *OK*, then *Save*
2. Route BDF to Edits Image Export Folder (This process resends the corrected image to [redacted])
   - ❖ In Formware Administration, open the **Files** folder
   - ❖ Open the job name of the batch to be routed
   - ❖ Highlight the BDF (Batch with the .BDF extension)
   - ❖ From the toolbar section select *Process*, then *Jobflow*, then *Autoclaims*, then *Edits-Image Export*, then *OK*.
3. Verify Images are stored on [redacted].
   - ❖ The day after the Images have been corrected and exported to [redacted], search for the range of ICN's that were corrected. If the images are displayed, the problem has been fixed and no other action is required.
   - ❖ If the images failed to load, open a ticket with the FHSC helpdesk for assistance from the [redacted] team.

Source 3 - Programming Issues:

Problems other than the two listed below are addressed with the support team at [redacted]

- An attachment identified as a form to be keyed opposed to an actual attachment.
- Batch contains duplicate ICN numbers.

8.0 Maintenance of Microsoft Access Database

Maintenance should be performed on the Microsoft Access database on a regular basis. This is to keep the database in peak performance.

8.1 Scheduled Database Maintenance

It is recommended this procedure be run at least weekly. This procedure must be run from a computer where Microsoft Access is installed. All JobFlow machines must be shutdown before this procedure is performed.

Procedure

1. From Windows Explorer, go to the I:\[redacted]\Database folder.
2. Make a backup copy of BatchCtrl.mdb.
   - ❖ Right click and select *Copy*.
   - ❖ Right click again select *Paste*.
   - ❖ Rename the copy file.
3. Double click on the BatchCtrl.mdb.
4. Microsoft Access Batch Control (2) screens will be displayed.
5. Close the **Switchboard** window by clicking on the *X* in the upper right corner (first screen).
6. Select *Tables* under the **Objects** column. (2nd screen)
7. Select *BatchControlLog*.
8. Select *Tools*.
9. Select *Database Utilities*.
10. Select *Compact and Repair Database*.
11. The **BatchCtrl: Database** window will close while the repair process is in progress.
12. When the process is finished, the **Switchboard** window will reappear.

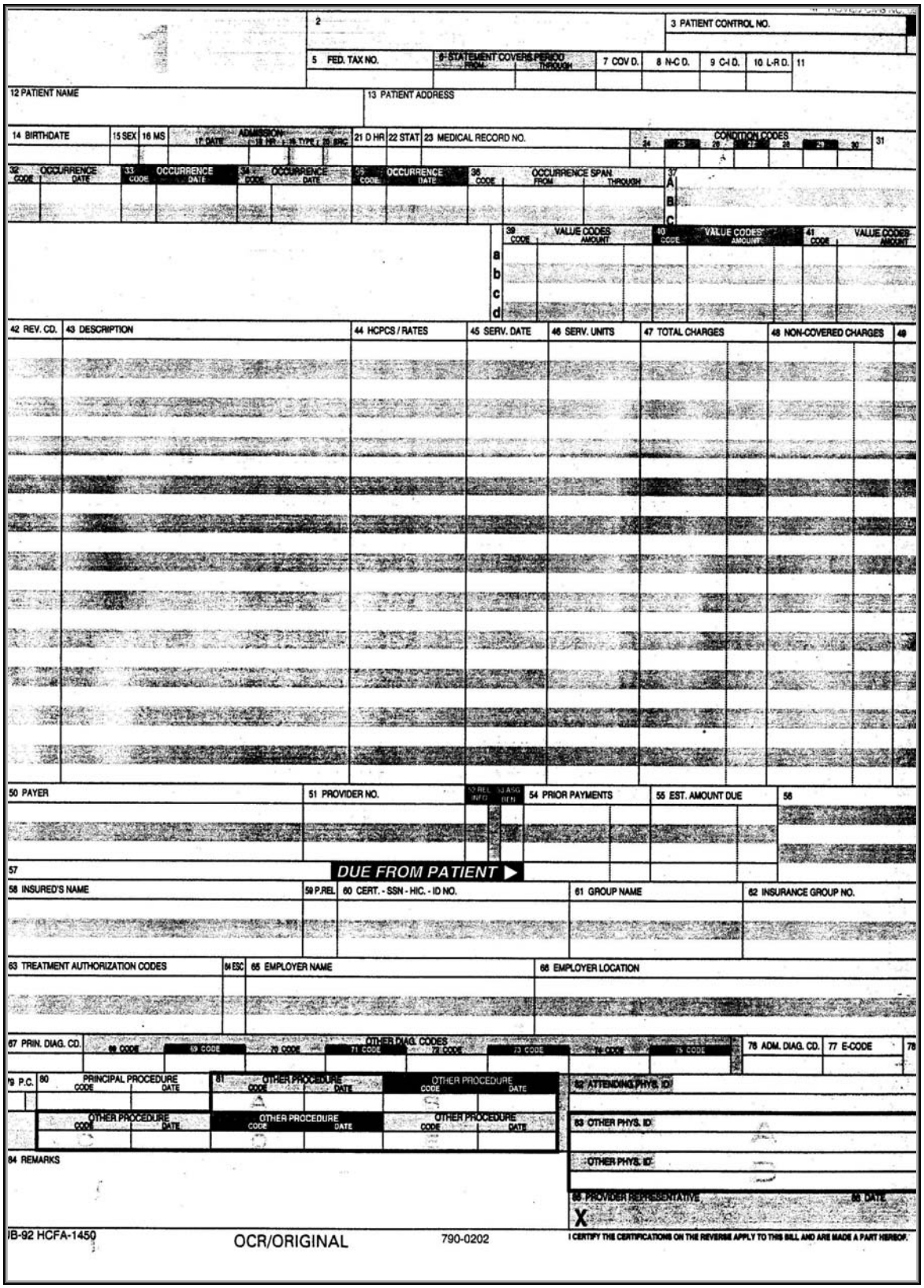
8.2 Deleting Old Records In Microsoft Access Database

This procedure is recommended at least once a year. This procedure must also be run from a computer where Microsoft Access is installed. All Job Flow machines must be shutdown before this procedure is performed.

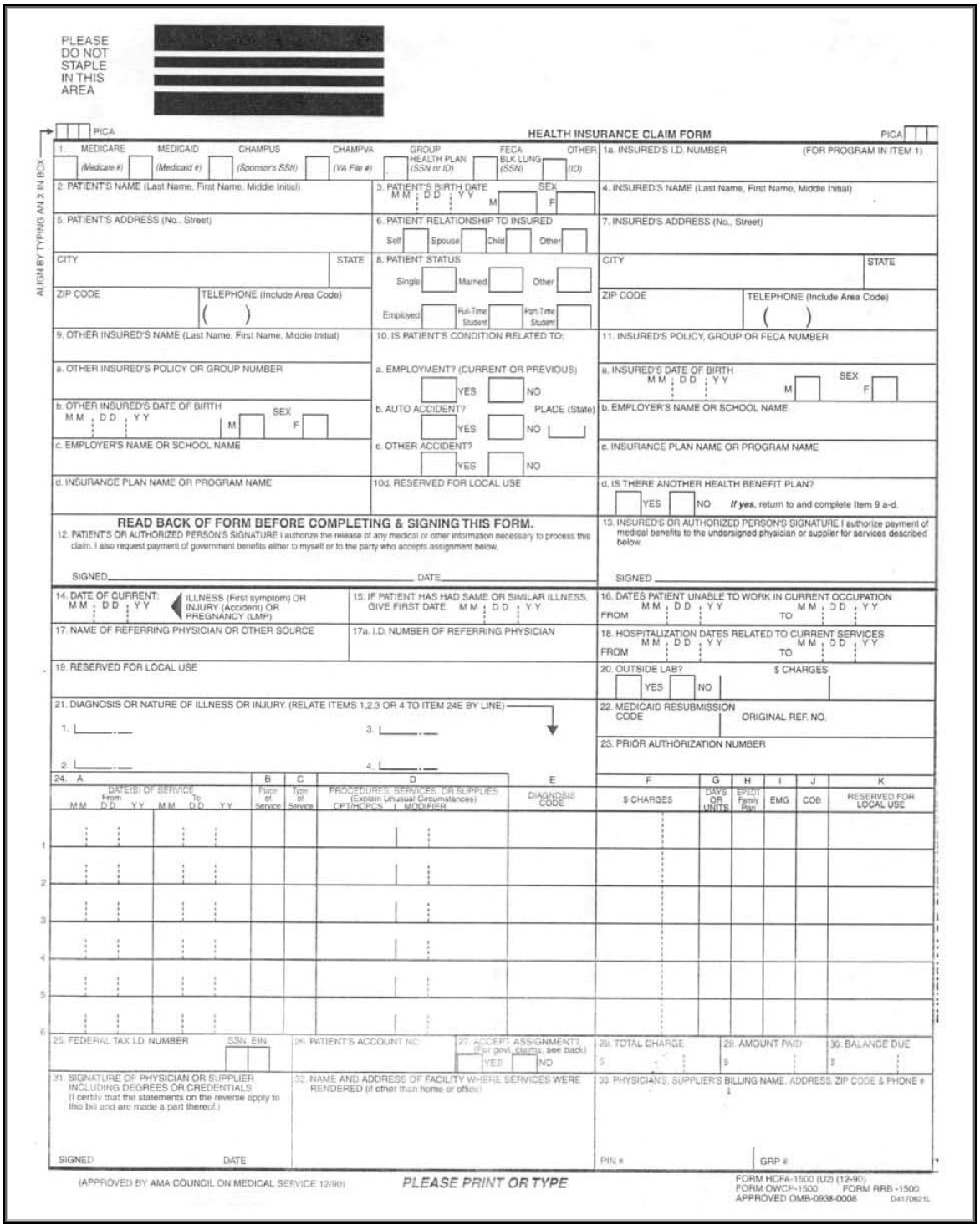
Procedure

1. From Windows Explorer, go to the I:\[redacted]\Database folder.
2. Make a backup copy of **BatchCtrl.mdb**.
3. Rename the copy file with the year.
4. Go to the Desktop and click on the **Batch Control Log** icon.
5. Close the **Switchboard** window by clicking on the *X* in the upper right corner.
6. Select *Table* under the **Objects** column.
7. Select *BatchControlLog*.
8. Highlight records to be deleted.
9. Then from the task bar select *Tools*, then *Database Utilities*, then *Compact Repair Database*.
10. When the process is finished, the **Switchboard** window will reappear.

Appendix A Input Forms



Sample UB-92 Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

ALIGN BY TYPING AN X IN BOX

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY, GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete Item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

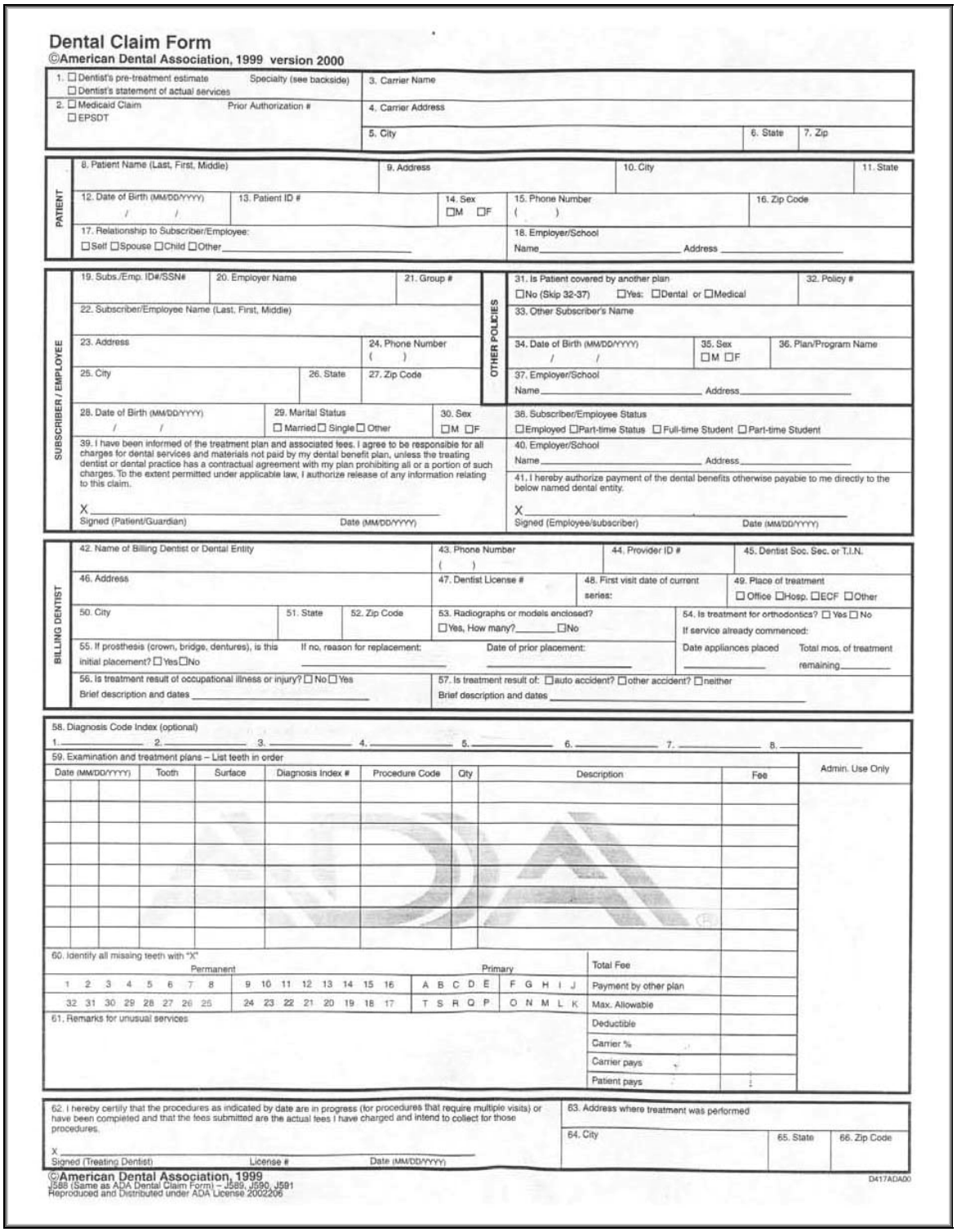
PIN # GRP #

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 12/90)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90)
FORM OWCP-1500 FORM RRB -1500
APPROVED OMB-0938-0008 D41706211

Sample HCFA-1500 Claim Form



Dental Claim Form

©American Dental Association, 1999 version 2000

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32-37) ☐Yes: ☐Dental or ☐Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: — Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐No ☐Yes Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17
Primary: A B C D E | F G H I J | T S R Q P | O N M L K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

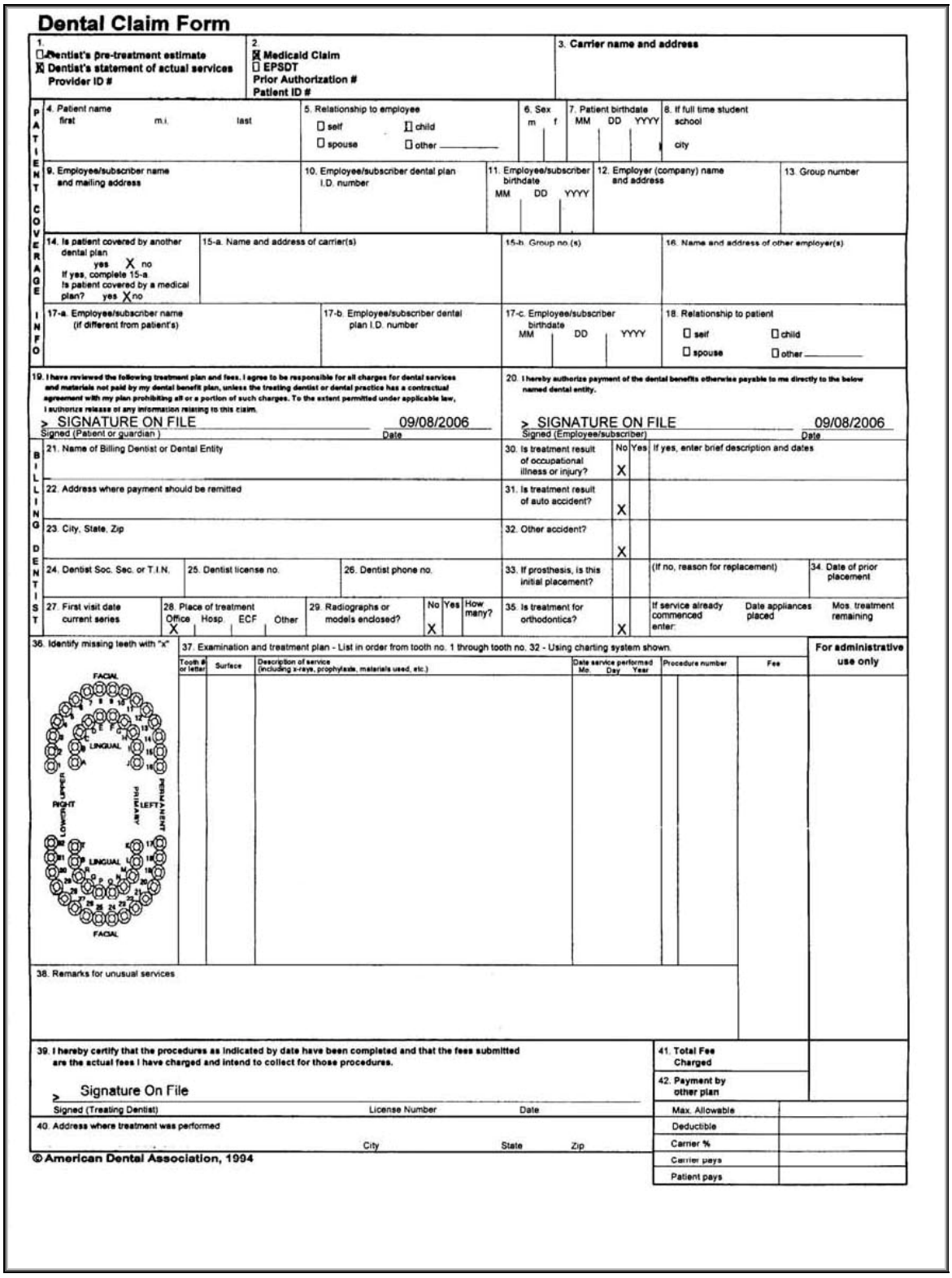
62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

©American Dental Association, 1999
J588 (Same as ADA Dental Claim Form) – J589, J590, J591
Reproduced and Distributed under ADA License 2002206

D417ADA00

Sample ADA (Dental) 1999 Claim Form



Dental Claim Form

1. ☐ Dentist's pre-treatment estimate
☒ Dentist's statement of actual services
Provider ID #

2. ☒ Medicaid Claim
☐ EPSDT
Prior Authorization #
Patient ID #

3. Carrier name and address

PATIENT COVERAGE INFO

4. Patient name — first / m.i. / last

5. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ other

6. Sex — m / f

7. Patient birthdate — MM DD YYYY

8. If full time student — school / city

9. Employee/subscriber name and mailing address

10. Employee/subscriber dental plan I.D. number

11. Employee/subscriber birthdate — MM DD YYYY

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan — yes X no
If yes, complete 15-a.
Is patient covered by a medical plan? yes X no

15-a. Name and address of carrier(s)

15-b. Group no.(s)

16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)

17-b. Employee/subscriber dental plan I.D. number

17-c. Employee/subscriber birthdate — MM DD YYYY

18. Relationship to patient — ☐ self ☐ child ☐ spouse ☐ other

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
> SIGNATURE ON FILE — 09/08/2006
Signed (Patient or guardian) — Date

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
> SIGNATURE ON FILE — 09/08/2006
Signed (Employee/subscriber) — Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity

22. Address where payment should be remitted

23. City, State, Zip

24. Dentist Soc. Sec. or T.I.N.

25. Dentist license no.

26. Dentist phone no.

27. First visit date current series

28. Place of treatment — Office X / Hosp / ECF / Other

29. Radiographs or models enclosed? — No X / Yes / How many?

30. Is treatment result of occupational illness or injury? — No X / Yes

31. Is treatment result of auto accident? — No X / Yes

32. Other accident? — No X / Yes

33. If prosthesis, is this initial placement? — No / Yes

(If no, reason for replacement)

34. Date of prior placement

35. Is treatment for orthodontics? — No X / Yes

If service already commenced enter:

Date appliances placed

Mos. treatment remaining

36. Identify missing teeth with "x"

37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

38. Remarks for unusual services

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
> Signature On File
Signed (Treating Dentist) — License Number — Date

40. Address where treatment was performed
City — State — Zip

41. Total Fee Charged

42. Payment by other plan

Max. Allowable

Deductible

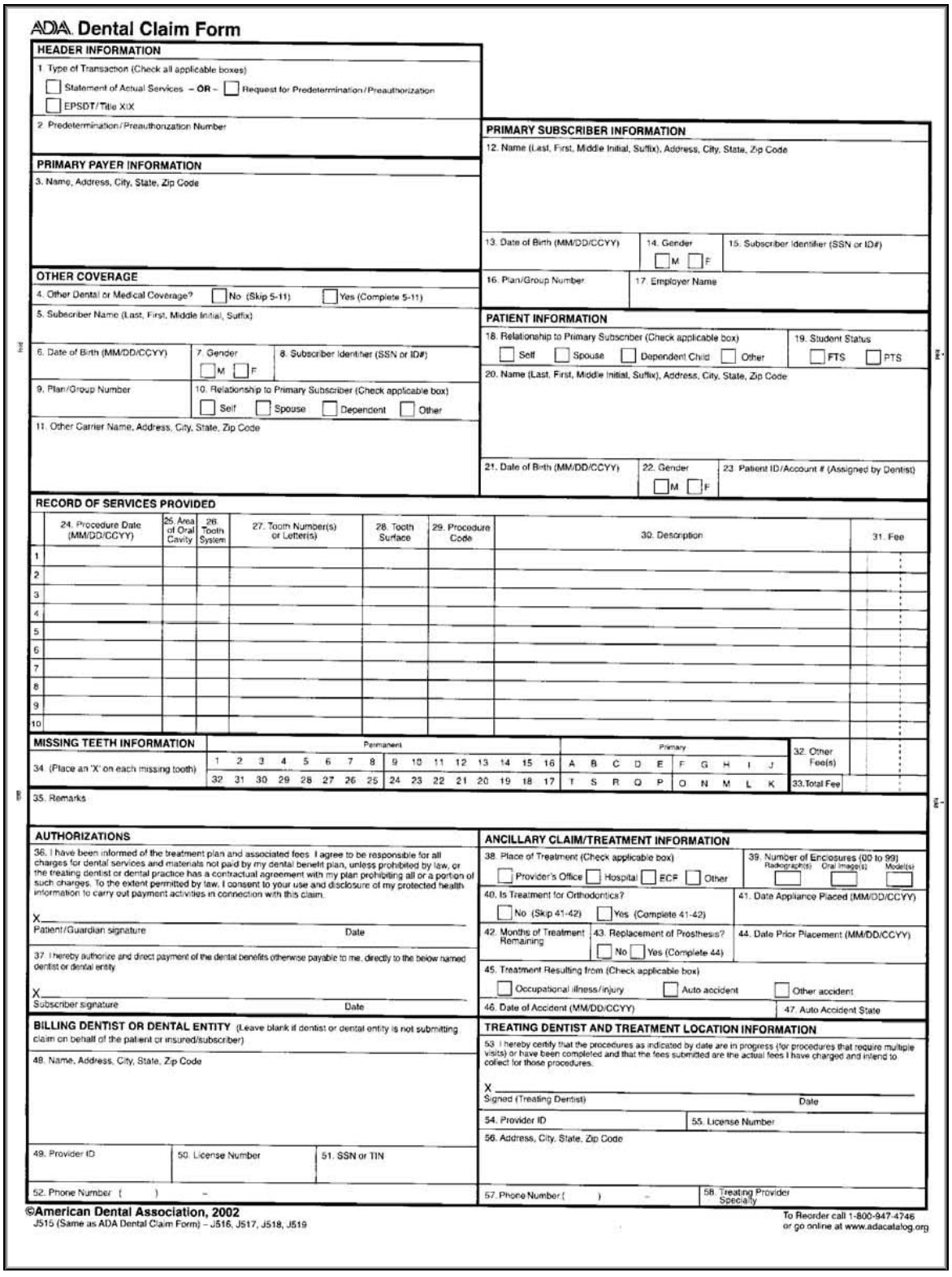
Carrier %

Carrier pays

Patient pays

© American Dental Association, 1994

Sample ADA (Dental) 1994 Claim Form



ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X
Patient/Guardian signature | Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature | Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other | 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X
Signed (Treating Dentist) | Date

54. Provider ID | 55. License Number

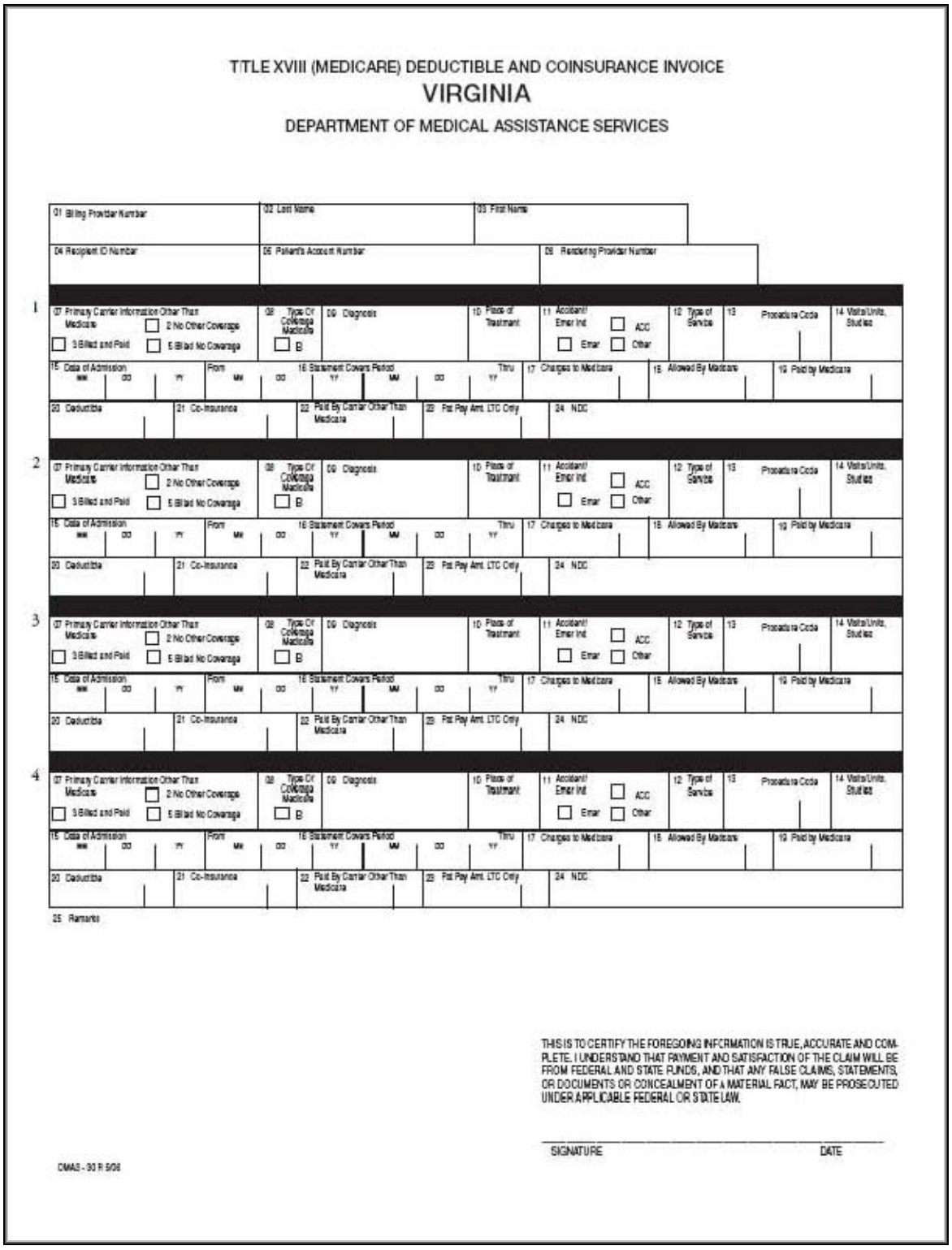
56. Address, City, State, Zip Code

57. Phone Number ( ) – | 58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

Sample ADA (Dental) 2002 Claim Form



TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Billing Provider Number | 02 Last Name | 03 First Name

04 Recipient ID Number | 05 Patient's Account Number | 06 Rendering Provider Number

1

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage | 08 Type Of Coverage Medicare ☐ B | 09 Diagnosis | 10 Place of Treatment | 11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other | 12 Type of Service | 13 Procedure Code | 14 Visits/Units, Studies

15 Date of Admission MM DD YY | From MM DD YY | 16 Statement Covers Period MM DD YY Thru MM DD YY | 17 Charges to Medicare | 18 Allowed By Medicare | 19 Paid by Medicare

20 Deductible | 21 Co-Insurance | 22 Paid By Carrier Other Than Medicare | 23 Pat Pay Amt. LTC Only | 24 NDC

2

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage | 08 Type Of Coverage Medicare ☐ B | 09 Diagnosis | 10 Place of Treatment | 11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other | 12 Type of Service | 13 Procedure Code | 14 Visits/Units, Studies

15 Date of Admission MM DD YY | From MM DD YY | 16 Statement Covers Period MM DD YY Thru MM DD YY | 17 Charges to Medicare | 18 Allowed By Medicare | 19 Paid by Medicare

20 Deductible | 21 Co-Insurance | 22 Paid By Carrier Other Than Medicare | 23 Pat Pay Amt. LTC Only | 24 NDC

3

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage | 08 Type Of Coverage Medicare ☐ B | 09 Diagnosis | 10 Place of Treatment | 11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other | 12 Type of Service | 13 Procedure Code | 14 Visits/Units, Studies

15 Date of Admission MM DD YY | From MM DD YY | 16 Statement Covers Period MM DD YY Thru MM DD YY | 17 Charges to Medicare | 18 Allowed By Medicare | 19 Paid by Medicare

20 Deductible | 21 Co-Insurance | 22 Paid By Carrier Other Than Medicare | 23 Pat Pay Amt. LTC Only | 24 NDC

4

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage | 08 Type Of Coverage Medicare ☐ B | 09 Diagnosis | 10 Place of Treatment | 11 Accident/ Emer Ind ☐ ACC ☐ Emer ☐ Other | 12 Type of Service | 13 Procedure Code | 14 Visits/Units, Studies

15 Date of Admission MM DD YY | From MM DD YY | 16 Statement Covers Period MM DD YY Thru MM DD YY | 17 Charges to Medicare | 18 Allowed By Medicare | 19 Paid by Medicare

20 Deductible | 21 Co-Insurance | 22 Paid By Carrier Other Than Medicare | 23 Pat Pay Amt. LTC Only | 24 NDC

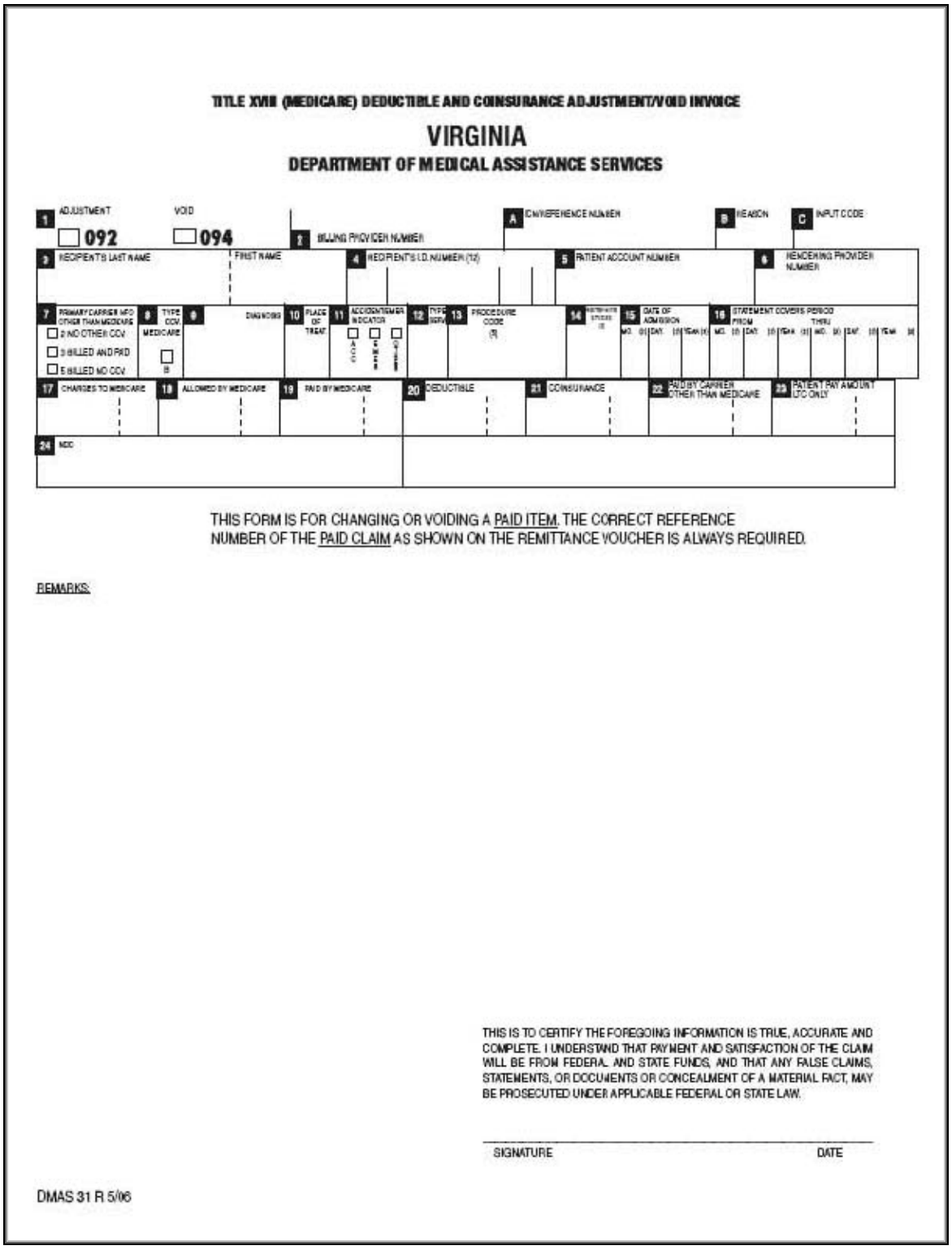
25 Remarks

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

DMAS - 93 R 5/08

Sample Title XVIII (Medicare) Deductible and Coinsurance Invoice



TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE ADJUSTMENT/VOID INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1 ADJUSTMENT ☐ 092 VOID ☐ 094 | 2 BILLING PROVIDER NUMBER | A CNV/REFERENCE NUMBER | B REASON | C INPUT CODE

3 RECIPIENT'S LAST NAME | FIRST NAME | 4 RECIPIENT'S I.D. NUMBER (12) | 5 PATIENT ACCOUNT NUMBER | 6 RENDERING PROVIDER NUMBER

7 PRIMARY CARRIER M/O OTHER THAN MEDICARE ☐ 2 NO OTHER COV ☐ 3 BILLED AND PAID ☐ 5 BILLED NO COV | 8 TYPE COV MEDICARE ☐ B | 9 DIAGNOSIS | 10 PLACE OF TREAT | 11 ACCIDENT/EMER INDICATOR ☐ ACCD ☐ EMER ☐ OTHER | 12 TYPE SERV | 13 PROCEDURE CODE (S) | 14 | 15 DATE OF ADMISSION MO DAY YEAR | 16 STATEMENT COVERS PERIOD FROM MO DAY YEAR THRU MO DAY YEAR

17 CHARGES TO MEDICARE | 18 ALLOWED BY MEDICARE | 19 PAID BY MEDICARE | 20 DEDUCTIBLE | 21 COINSURANCE | 22 PAID BY CARRIER OTHER THAN MEDICARE | 23 PATIENT PAY AMOUNT LTC ONLY

24 NDC

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

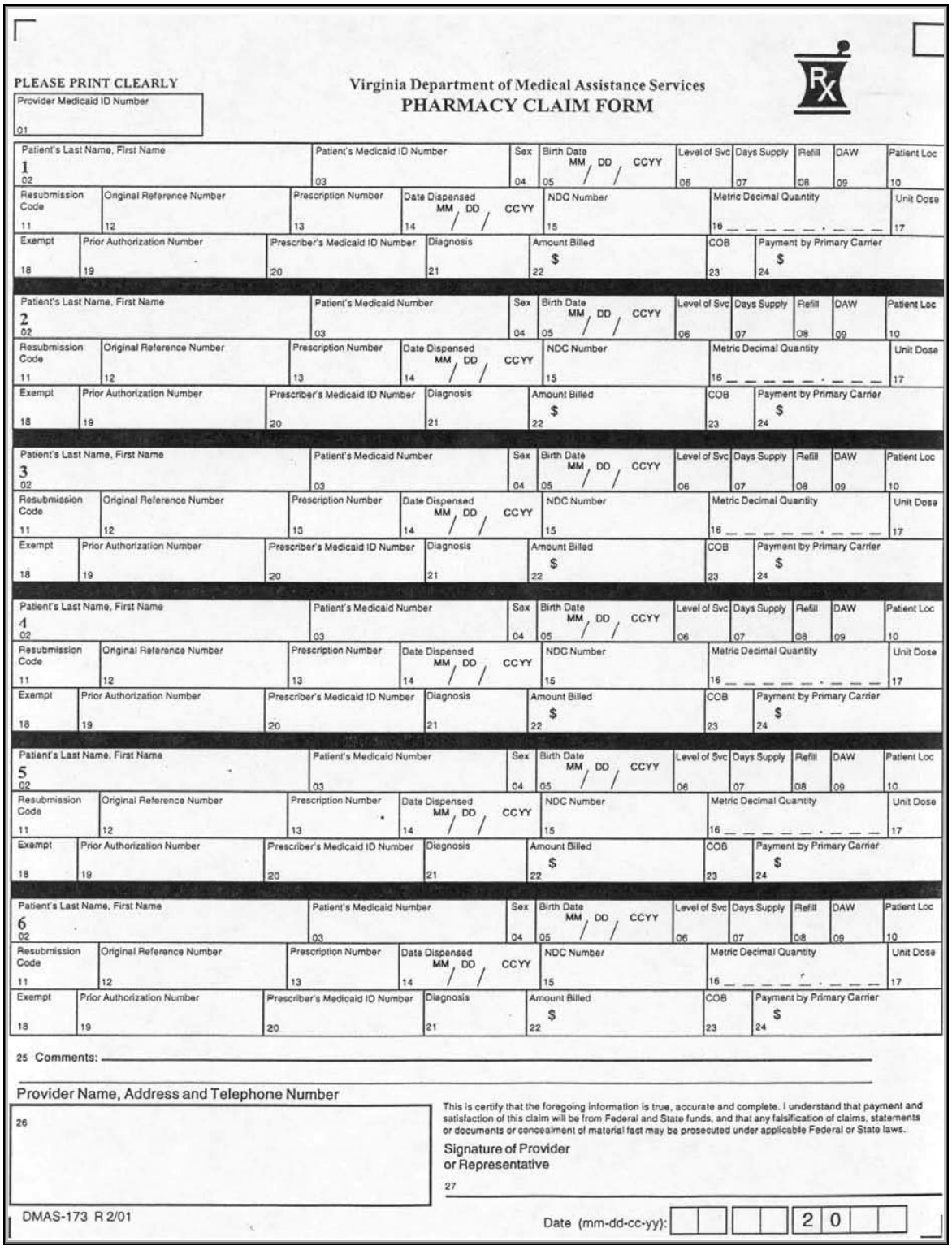
REMARKS:

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

DMAS 31 R 5/06

Sample Title XVIII (Medicare) Adjustment Form



PLEASE PRINT CLEARLY

Provider Medicaid ID Number 01

Virginia Department of Medical Assistance Services

PHARMACY CLAIM FORM

Patient's Last Name, First Name 02	Patient's Medicaid ID Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
1								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

Patient's Last Name, First Name 02	Patient's Medicaid Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
2								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

Patient's Last Name, First Name 02	Patient's Medicaid Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
3								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

Patient's Last Name, First Name 02	Patient's Medicaid Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
4								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

Patient's Last Name, First Name 02	Patient's Medicaid Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
5								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

Patient's Last Name, First Name 02	Patient's Medicaid Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
6								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

25 Comments: _____

Provider Name, Address and Telephone Number

26

This is certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

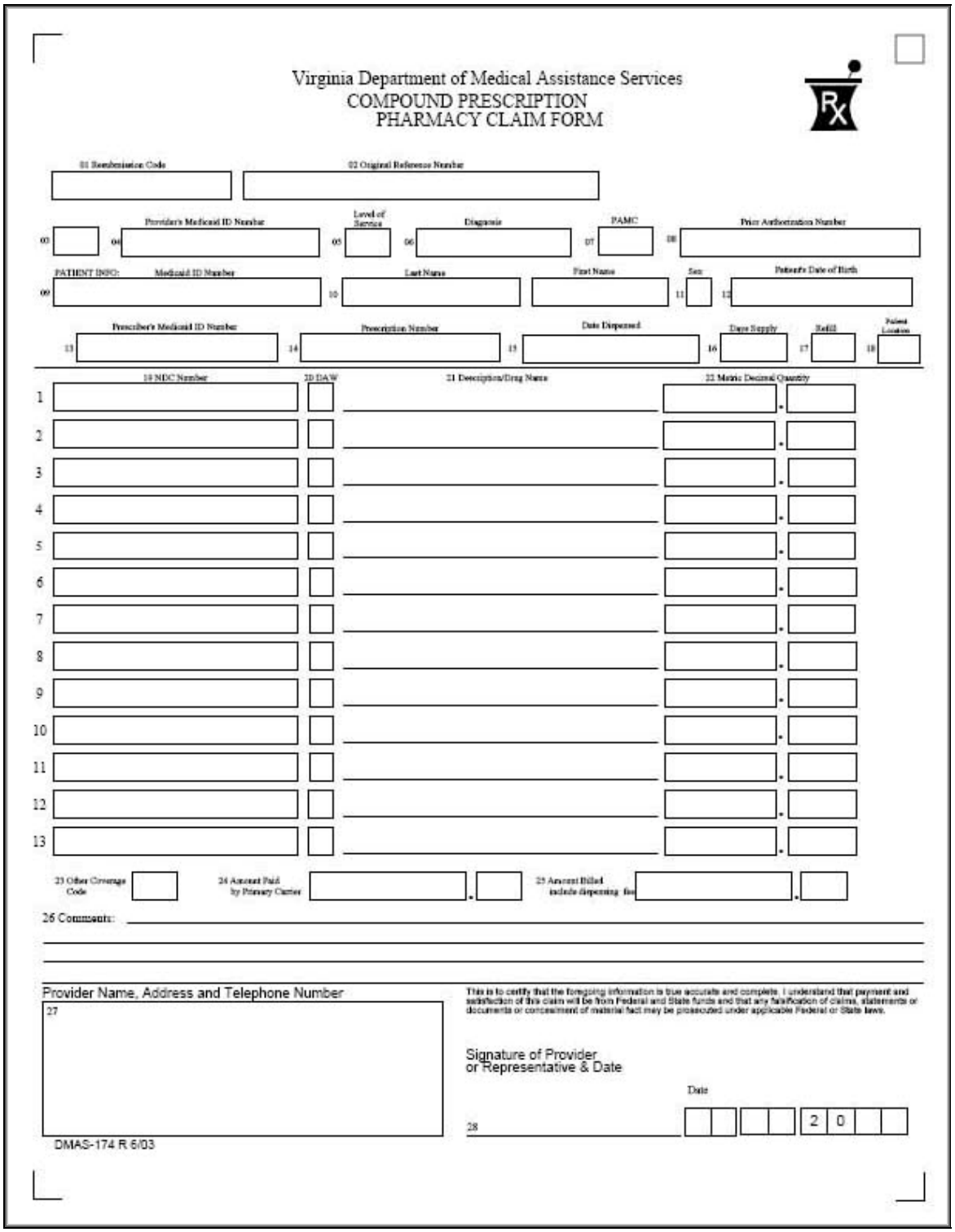
Signature of Provider or Representative

27

DMAS-173 R 2/01

Date (mm-dd-cc-yy): 2 0

Sample VDMAS Pharmacy Claim Form



Virginia Department of Medical Assistance Services
COMPOUND PRESCRIPTION
PHARMACY CLAIM FORM

01 Resubmission Code | 02 Original Reference Number

03 | 04 Provider's Medicaid ID Number | 05 Level of Service | 06 Diagnosis | 07 PAMC | 08 Prior Authorization Number

PATIENT INFO: 09 Medicaid ID Number | 10 Last Name | First Name | 11 Sex | 12 Patient's Date of Birth

13 Prescriber's Medicaid ID Number | 14 Prescription Number | 15 Date Dispensed | 16 Days Supply | 17 Refill | 18 Patient Location

	19 NDC Number	20 DAW	21 Description/Drug Name	22 Metric Decimal Quantity
1				.
2				.
3				.
4				.
5				.
6				.
7				.
8				.
9				.
10				.
11				.
12				.
13				.

23 Other Coverage Code | 24 Amount Paid by Primary Carrier | 25 Amount Billed include dispensing fee

26 Comments:

Provider Name, Address and Telephone Number
27

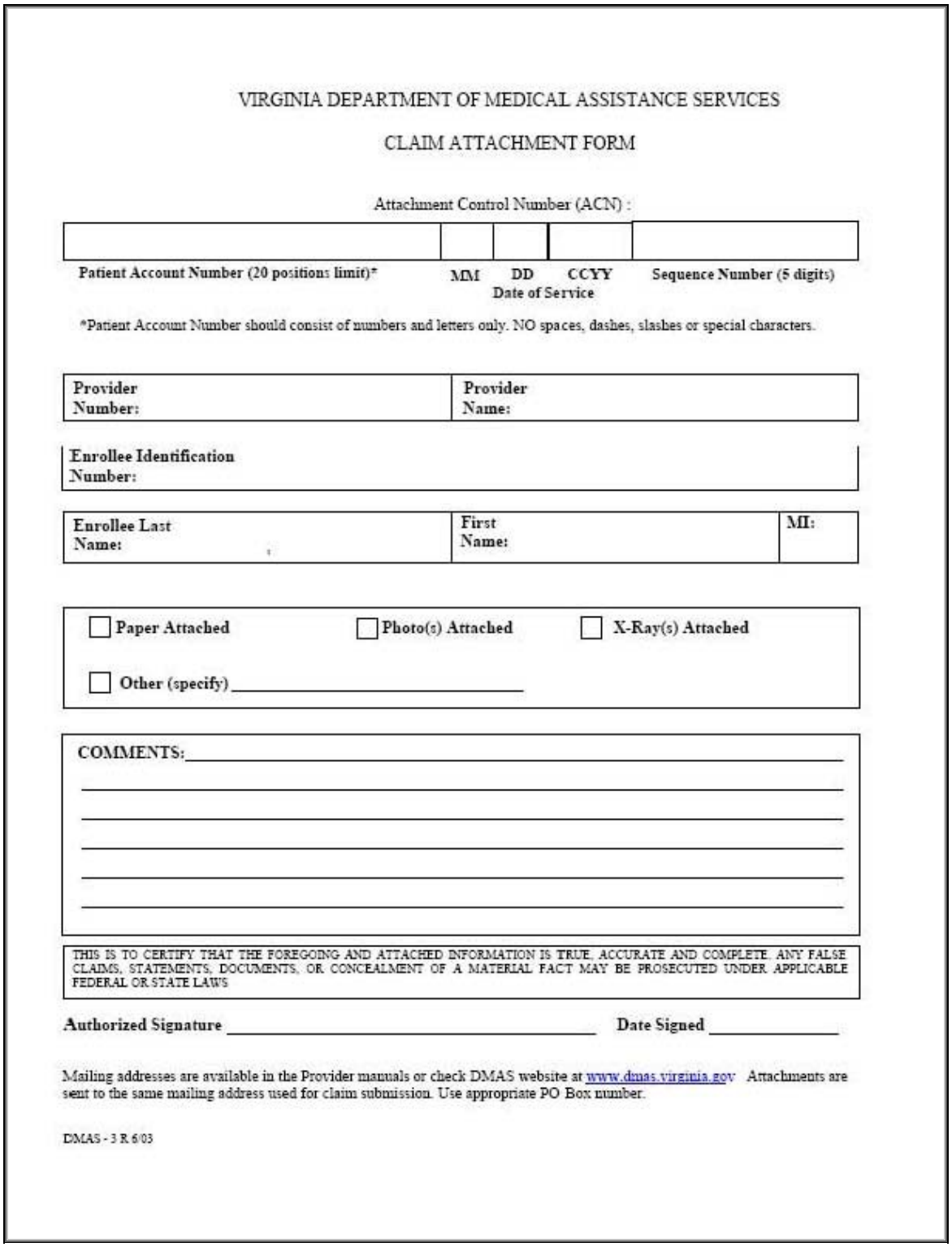
This is to certify that the foregoing information is true accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any falsification of claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

Signature of Provider or Representative & Date
28

Date 2 0

DMAS-174 R 6/03

Sample VDMAS Compound Prescription Pharmacy Claim Form



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	MM	DD	CCYY	Sequence Number (5 digits)
	Date of Service			

*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	Provider Name:

Enrollee Identification Number:

Enrollee Last Name:	First Name:	MI:

☐ Paper Attached ☐ Photo(s) Attached ☐ X-Ray(s) Attached

☐ Other (specify) _____

COMMENTS: _____

_____

_____

_____

_____

_____

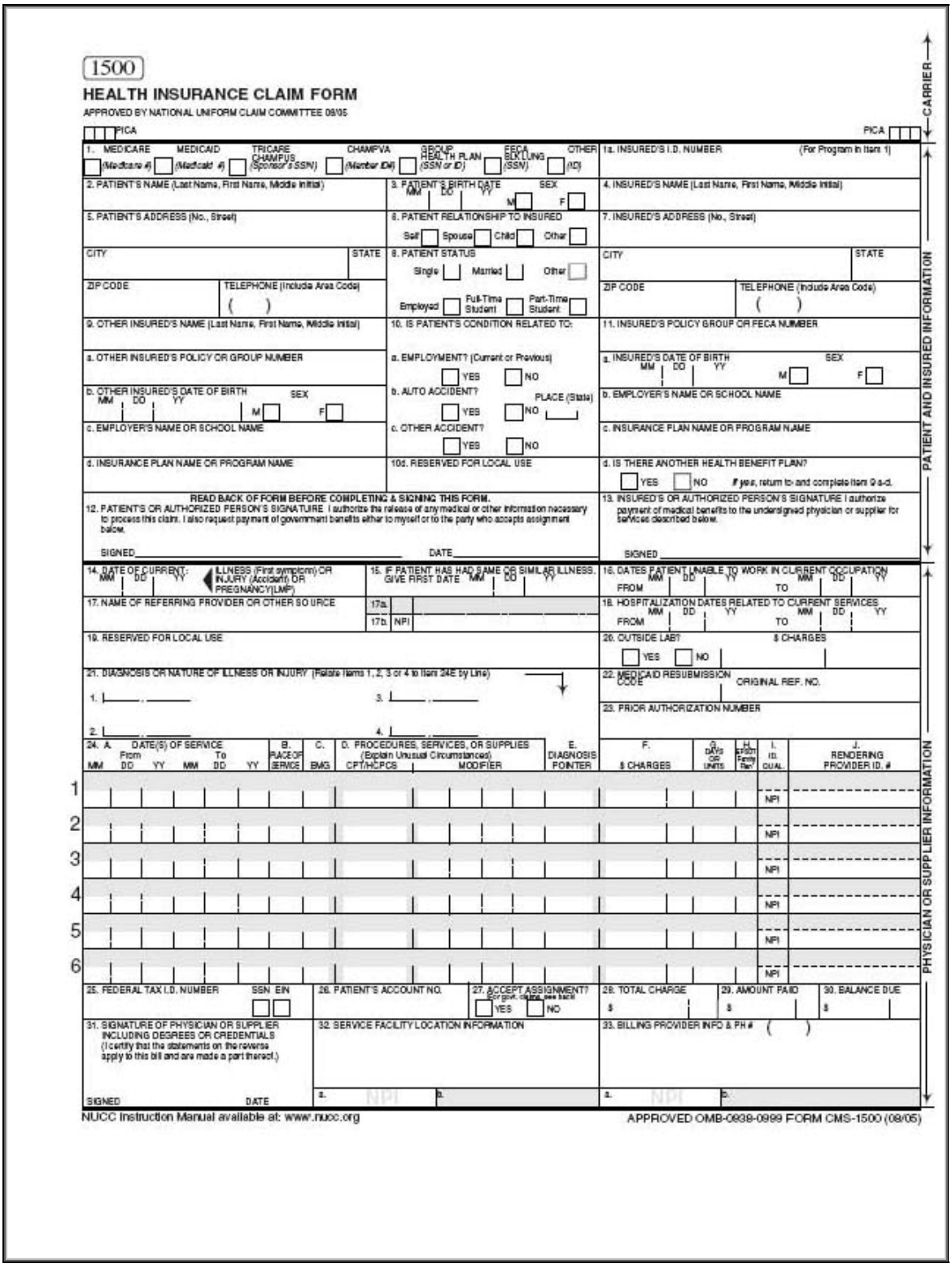
THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

Authorized Signature _____ Date Signed _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.virginia.gov Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS - 3 R 6/03

Sample VDMAS Claim Attachment Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

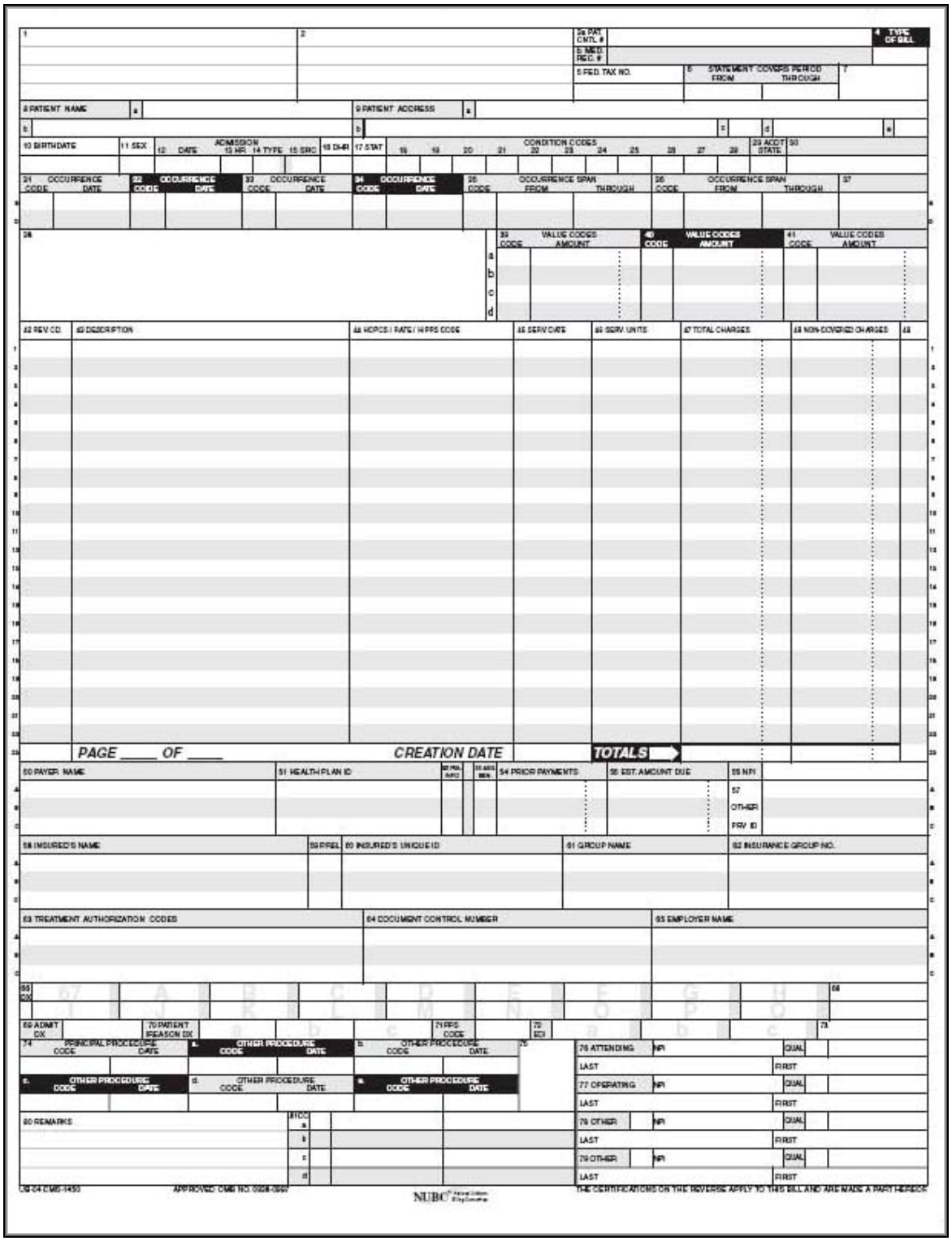
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

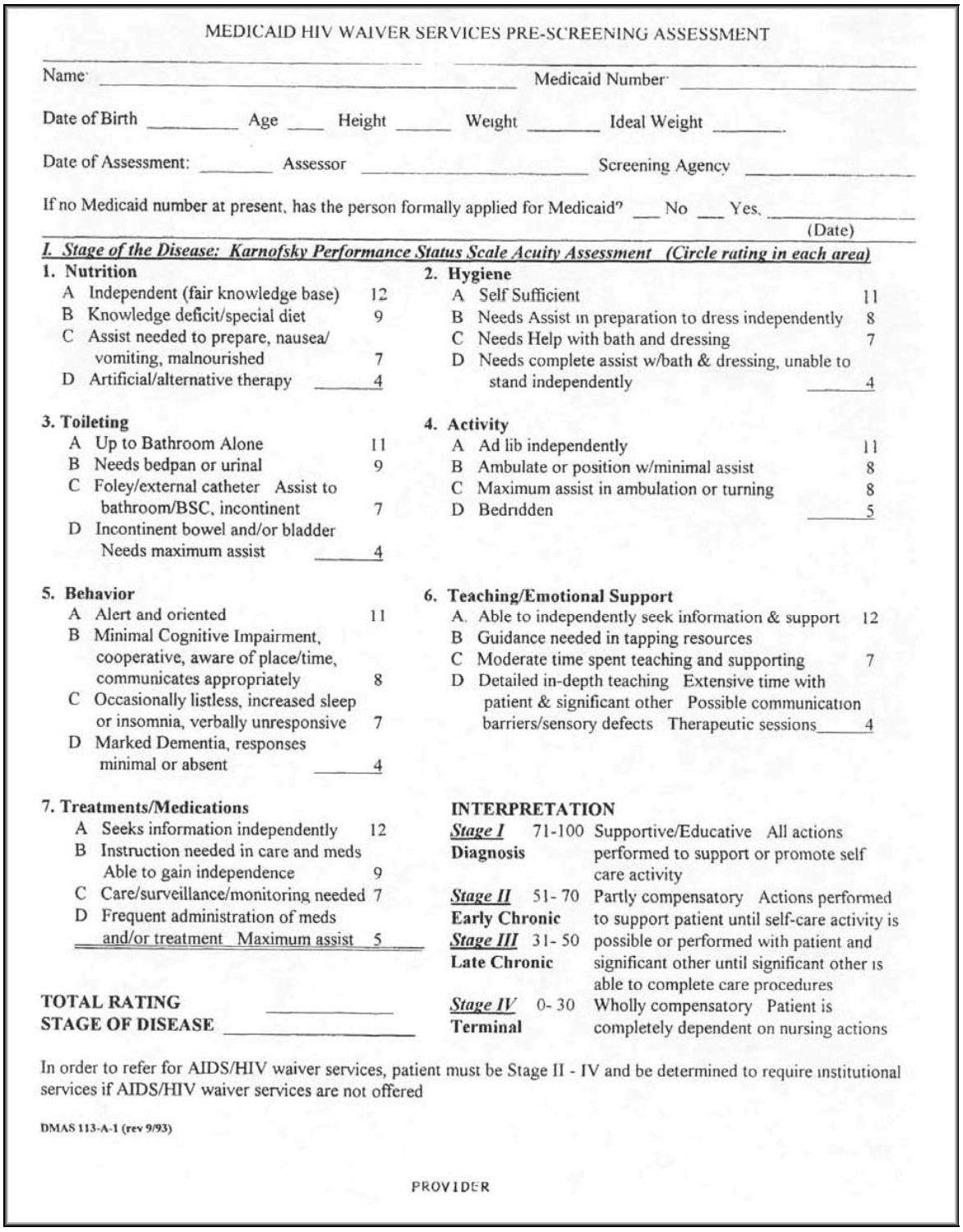
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample HCFA CMS 1500


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
CONDITION CODES
28 ACCT STATE
29
30
31 CODE OCCURRENCE DATE
32 CODE OCCURRENCE DATE
33 CODE OCCURRENCE DATE
34 CODE OCCURRENCE DATE
35 CODE OCCURRENCE SPAN FROM THROUGH
36 CODE OCCURRENCE SPAN FROM THROUGH
37
38
39 CODE VALUE CODES AMOUNT
40 CODE VALUE CODES AMOUNT
41 CODE VALUE CODES AMOUNT
42 REV CD
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV DATE
46 SERV UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67 A B C D E F G H I J K L
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
80 REMARKS
80 CC
a
b
c
d
CMS-1450
APPROVED OMB NO. 0938-0997
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Sample UB04



MEDICAID HIV WAIVER SERVICES PRE-SCREENING ASSESSMENT

Name: _____ Medicaid Number: _____

Date of Birth _____ Age ____ Height _____ Weight _____ Ideal Weight _____

Date of Assessment: _____ Assessor _____ Screening Agency _____

If no Medicaid number at present, has the person formally applied for Medicaid? ___ No ___ Yes, _____ (Date)

I. Stage of the Disease: Karnofsky Performance Status Scale Acuity Assessment (Circle rating in each area)

1. Nutrition
- A Independent (fair knowledge base) 12
- B Knowledge deficit/special diet 9
- C Assist needed to prepare, nausea/ vomiting, malnourished 7
- D Artificial/alternative therapy 4

2. Hygiene
- A Self Sufficient 11
- B Needs Assist in preparation to dress independently 8
- C Needs Help with bath and dressing 7
- D Needs complete assist w/bath & dressing, unable to stand independently 4

3. Toileting
- A Up to Bathroom Alone 11
- B Needs bedpan or urinal 9
- C Foley/external catheter Assist to bathroom/BSC, incontinent 7
- D Incontinent bowel and/or bladder Needs maximum assist 4

4. Activity
- A Ad lib independently 11
- B Ambulate or position w/minimal assist 8
- C Maximum assist in ambulation or turning 8
- D Bedridden 5

5. Behavior
- A Alert and oriented 11
- B Minimal Cognitive Impairment, cooperative, aware of place/time, communicates appropriately 8
- C Occasionally listless, increased sleep or insomnia, verbally unresponsive 7
- D Marked Dementia, responses minimal or absent 4

6. Teaching/Emotional Support
- A. Able to independently seek information & support 12
- B Guidance needed in tapping resources
- C Moderate time spent teaching and supporting 7
- D Detailed in-depth teaching Extensive time with patient & significant other Possible communication barriers/sensory defects Therapeutic sessions 4

7. Treatments/Medications
- A Seeks information independently 12
- B Instruction needed in care and meds Able to gain independence 9
- C Care/surveillance/monitoring needed 7
- D Frequent administration of meds and/or treatment Maximum assist 5

INTERPRETATION

Stage I **Diagnosis**	71-100	Supportive/Educative All actions performed to support or promote self care activity
Stage II **Early Chronic**	51- 70	Partly compensatory Actions performed to support patient until self-care activity is possible or performed with patient and significant other until significant other is able to complete care procedures
Stage III **Late Chronic**	31- 50	
Stage IV **Terminal**	0- 30	Wholly compensatory Patient is completely dependent on nursing actions

TOTAL RATING _____

STAGE OF DISEASE _____

In order to refer for AIDS/HIV waiver services, patient must be Stage II - IV and be determined to require institutional services if AIDS/HIV waiver services are not offered

DMAS 113-A-1 (rev 9/93)

PROVIDER

Sample DMAS 113A Medicaid HIV Waiver Services Pre-Screening Assessment

II. Describe type of assistance needed; include frequency & average amount (i.e. good and bad days)

III. Medical Condition:

1 Attending Physician: _____ Address: _____
Phone # _____ Pharmacy: _____ Phone # _____

2. Primary Diagnosis: _____ Date of Onset _____

3 Other Diagnoses & Dates of Onset: _____

4 Check any of the following conditions affecting the diagnoses and necessitating requested services:
Wasting Syndrome _____ Dsyphagia _____ Dementia _____ Debilitating weakness _____
Mental disorder _____ Decubitis _____ Pain _____ Skin Lesions _____
Other _____

5. Describe recent medical history, including frequency of Physician/Clinic/Hospital visits: _____

6. Lab Work White Cell Count _____ CD-4 count _____ Percent _____ H/H _____
Serum Albumin _____ Other _____

7. Medications: Name Frequency Route of Administration Dosage

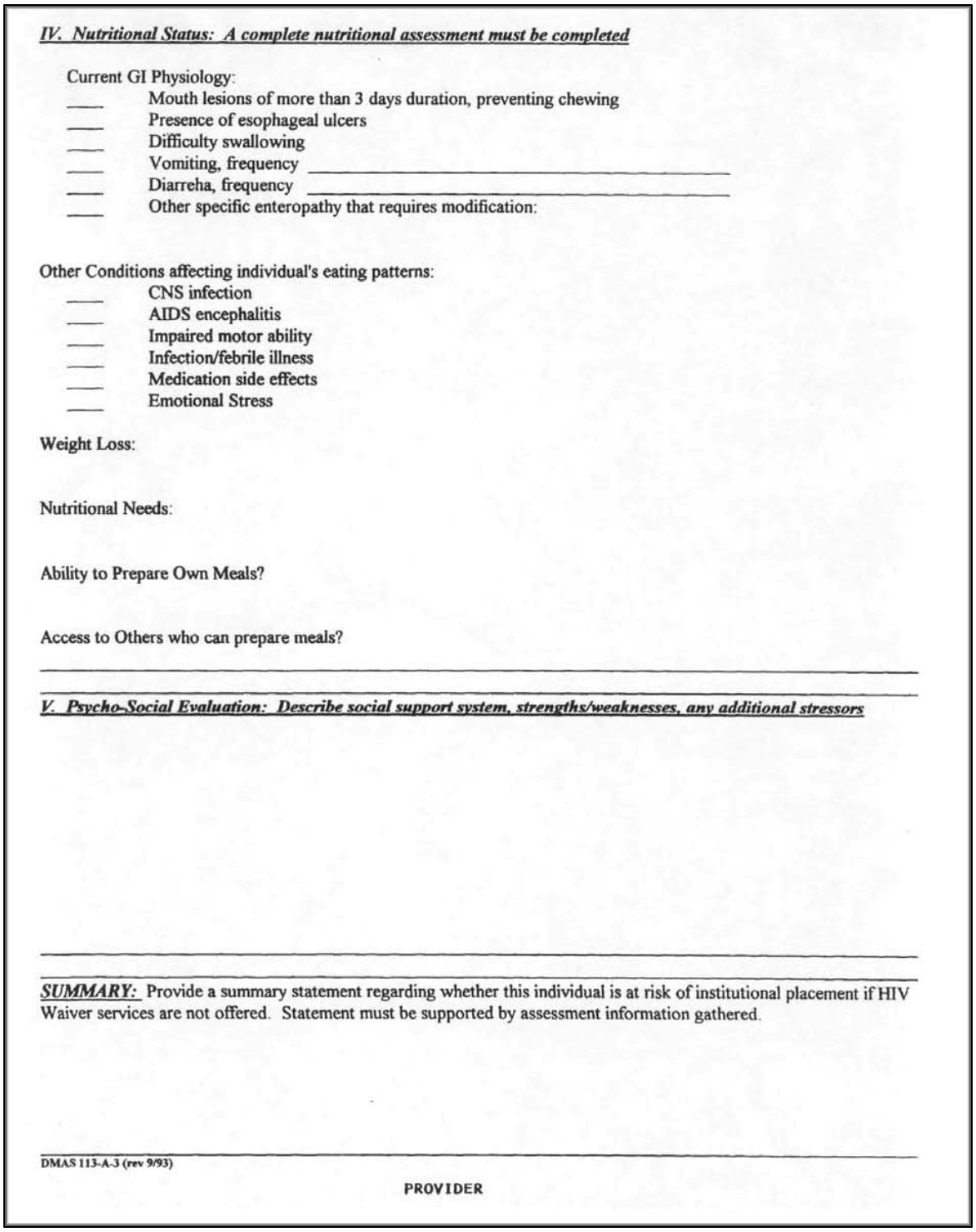
8 Nursing Care Needs· Check any that apply, note any others not indicated and provide any necessary description

IV, IM, SC injections daily ___	IV or Hyperal Therapy ___	NG, PEG, Gastrostomy feedings ___
Daily Sterile Dressing ___	Stage III or IV Decubitus ___	Skilled 24 hour nursing ___
Intermittent Injections ___	Oral, Topical, Instilled meds ___	Supervision of tube feeds, self care ___

DMAS 113-A-2 (rev 9/93)

PROVIDER

Sample DMAS 113A Medicaid HIV Waiver Services Pre-Screening Assessment



IV. Nutritional Status: A complete nutritional assessment must be completed

Current GI Physiology:

____ Mouth lesions of more than 3 days duration, preventing chewing
____ Presence of esophageal ulcers
____ Difficulty swallowing
____ Vomiting, frequency _____
____ Diarreha, frequency _____
____ Other specific enteropathy that requires modification:

Other Conditions affecting individual's eating patterns:

____ CNS infection
____ AIDS encephalitis
____ Impaired motor ability
____ Infection/febrile illness
____ Medication side effects
____ Emotional Stress

Weight Loss:

Nutritional Needs:

Ability to Prepare Own Meals?

Access to Others who can prepare meals?

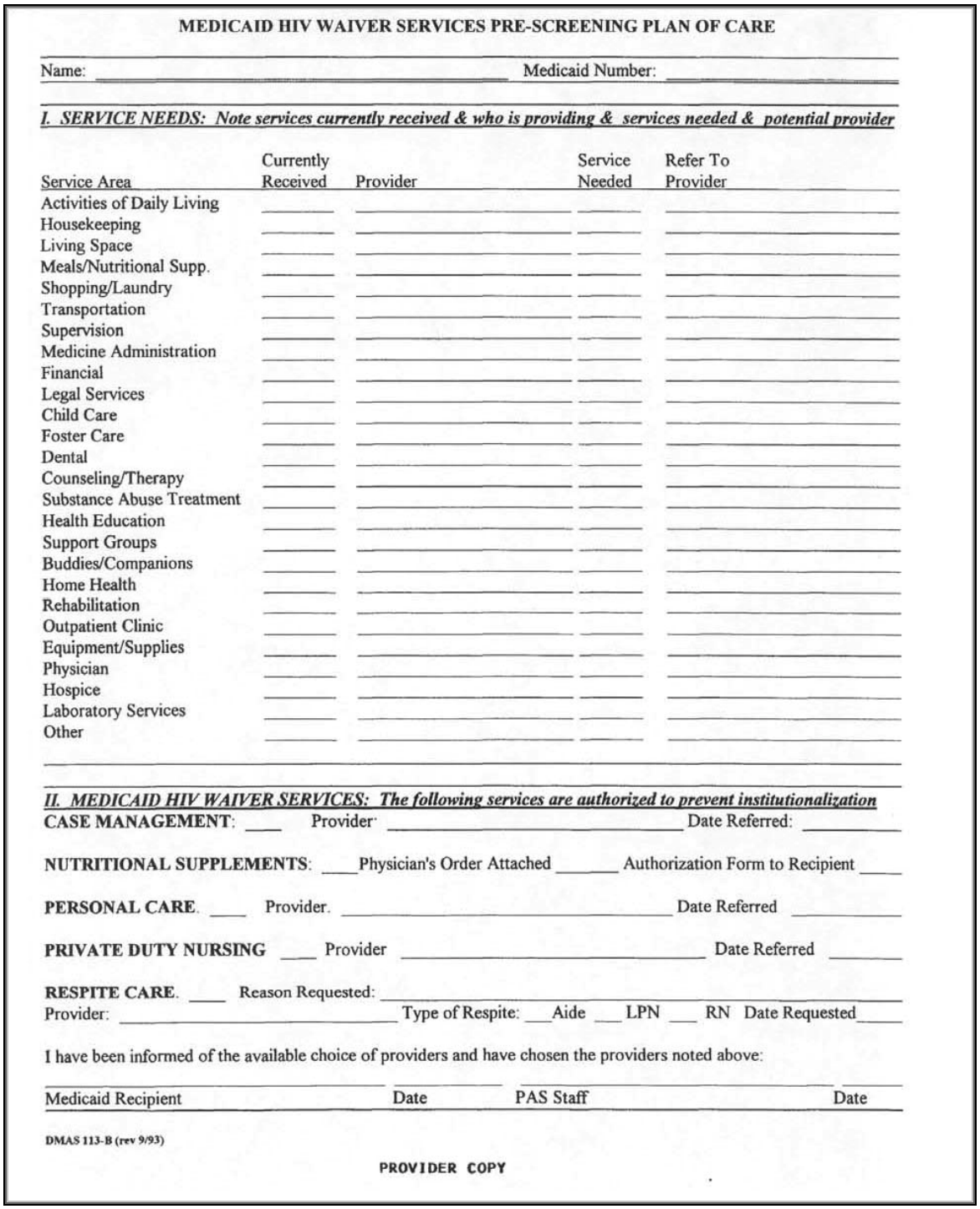
V. Psycho-Social Evaluation: Describe social support system, strengths/weaknesses, any additional stressors

SUMMARY: Provide a summary statement regarding whether this individual is at risk of institutional placement if HIV Waiver services are not offered. Statement must be supported by assessment information gathered.

DMAS 113-A-3 (rev 9/93)

PROVIDER

Sample DMAS 113A Medicaid HIV Waiver Services Pre-Screening Assessment



MEDICAID HIV WAIVER SERVICES PRE-SCREENING PLAN OF CARE

Name: _____ Medicaid Number: _____

I. SERVICE NEEDS: Note services currently received & who is providing & services needed & potential provider

Service Area	Currently Received	Provider	Service Needed	Refer To Provider
Activities of Daily Living				
Housekeeping				
Living Space				
Meals/Nutritional Supp.				
Shopping/Laundry				
Transportation				
Supervision				
Medicine Administration				
Financial				
Legal Services				
Child Care				
Foster Care				
Dental				
Counseling/Therapy				
Substance Abuse Treatment				
Health Education				
Support Groups				
Buddies/Companions				
Home Health				
Rehabilitation				
Outpatient Clinic				
Equipment/Supplies				
Physician				
Hospice				
Laboratory Services				
Other				

II. MEDICAID HIV WAIVER SERVICES: The following services are authorized to prevent institutionalization

CASE MANAGEMENT: ____ Provider: _____ Date Referred: _____

NUTRITIONAL SUPPLEMENTS: ____Physician's Order Attached _____ Authorization Form to Recipient ____

PERSONAL CARE. ____ Provider. _____ Date Referred _____

PRIVATE DUTY NURSING ____ Provider _____ Date Referred _____

RESPITE CARE. ____ Reason Requested: _____

Provider: _____ Type of Respite: ___Aide ___LPN ___ RN Date Requested_____

I have been informed of the available choice of providers and have chosen the providers noted above:

Medicaid Recipient _____ Date _____ PAS Staff _____ Date _____

DMAS 113-B (rev 9/93)

PROVIDER COPY

Sample DMAS 113B Medicaid HIV Waiver Services Plan of Care

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ___/___/_____

Social Security_____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐
1 = Yes
2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.
3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid? ☐
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible? ☐
0 = No
1 = Yes, or has applied for Auxiliary Grant
2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION
Level of Care ☐
1 = Nursing Facility Services
2 = PACE/LTCPHP
3 = AIDS/HIV Waiver Services
4 = Elderly or Disabled with Consumer Direction Waiver
11 = ALF Residential Living
12 = ALF Regular Assisted Living
14 = Individual/Family Developmental Disabilities Waiver
15 = Technology Assisted Waiver
16 = Alzheimer's Assisted Living Waiver

NOTE: Authorization for Nursing Facility or the Elderly or Disabled with Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same. Alzheimer's Assisted Living Waiver's alternate institutional placement is a nursing facility, however, the individual must also have a diagnosis of Alzheimer's Or Alzheimer's Related Dementia and meet the nursing facility criteria to qualify.

NO MEDICAID SERVICES AUTHORIZED
8 = Other Services Recommended
9 = Active Treatment for MI/MR Condition
0 = No other services recommended

Targeted Case Management for ALF ☐
0 = No 1 = Yes

Assessment Completed ☐
1 = Full Assessment 2 = Short Assessment

ALF provider name: _____
ALF provider number: _____
ALF admit date: _____

SERVICE AVAILABILITY ☐
1 = Client on waiting list for service authorized
2 = Desired service provider not available
3 = Service provider available, care to start immediately

LENGTH OF STAY (If approved for Nursing Home) ☐
1 = Temporary (less than 3 months)
2 = Temporary..(less than 6 months)
3 = Continuing (more than 6 months)
8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility and the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION
Name of Level I/ALF screener agency and provider number:

1._____
☐☐☐☐☐☐☐☐☐☐

2._____
☐☐☐☐☐☐☐☐☐☐

LEVEL II OR CSB 101B ASSESSMENT DETERMINATION
Name of Level II OR CSB Screener and ID number who have comple the Level II or 101B for a diagnosis of MI, MR, or RC.

1._____
☐☐☐☐☐☐☐☐☐☐

0 = Not referred for Level II OR 101B assessment
1 = Referred, Active Treatment needed
2 = Referred, Active Treatment not needed
3 = Referred, Active Treatment needed but individual chooses NF ☐

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No ☐

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

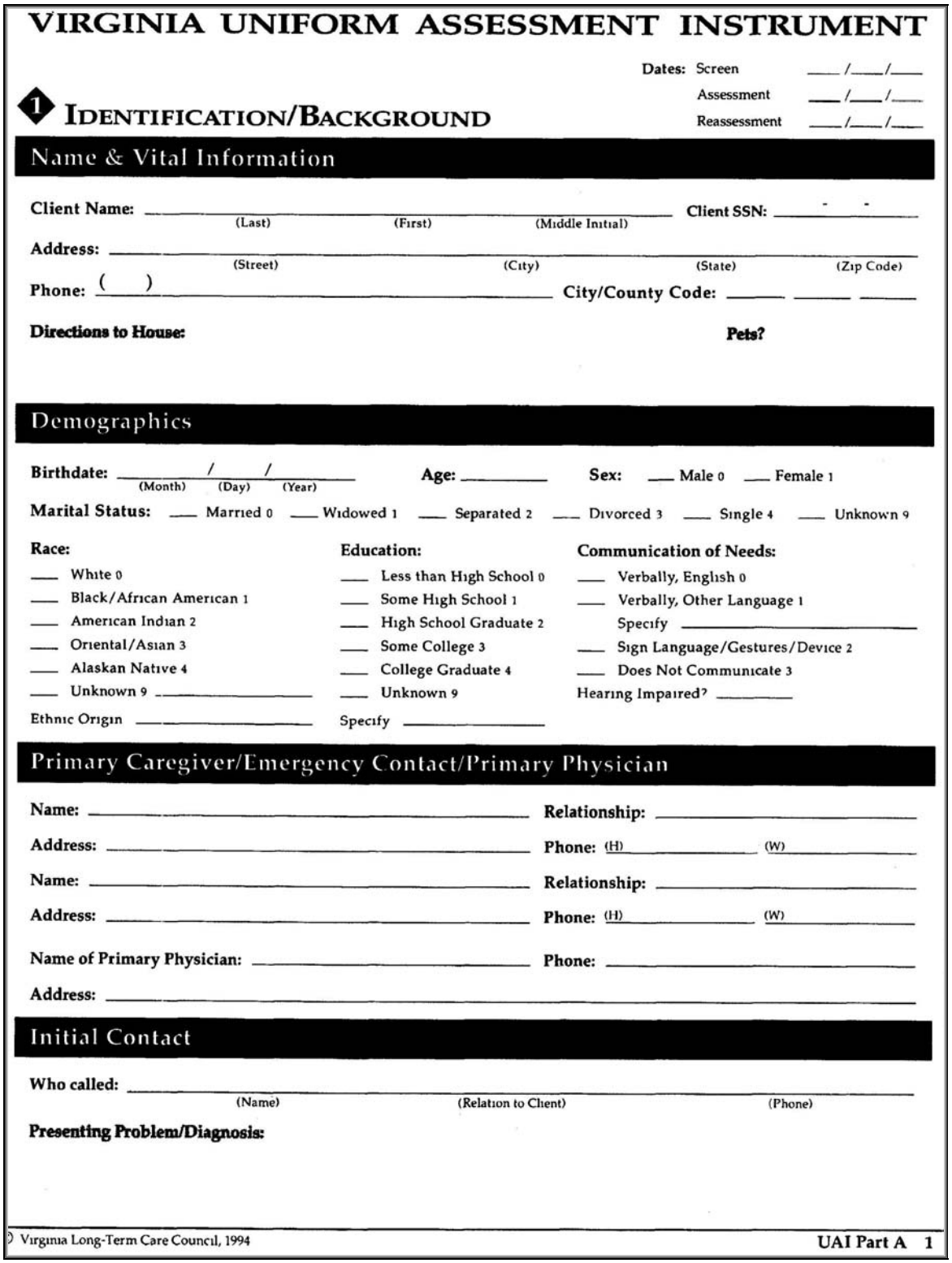
_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I Physician **Date**

DMAS-96 (revised 10/06)

Sample DMAS 96 Medicaid Funded LTC Pre-Admission Screening Authorization



VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen ___/___/___
Assessment ___/___/___
Reassessment ___/___/___

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ (Last) (First) (Middle Initial) **Client SSN:** ___-___-____

Address: _____ (Street) (City) (State) (Zip Code)

Phone: ( ) _____ **City/County Code:** _____ _____ _____

Directions to House:

Pets?

Demographics

Birthdate: ___/___/___ (Month) (Day) (Year) **Age:** _____ **Sex:** ___ Male 0 ___ Female 1

Marital Status: ___ Married 0 ___ Widowed 1 ___ Separated 2 ___ Divorced 3 ___ Single 4 ___ Unknown 9

Race:
___ White 0
___ Black/African American 1
___ American Indian 2
___ Oriental/Asian 3
___ Alaskan Native 4
___ Unknown 9 _____
Ethnic Origin _____

Education:
___ Less than High School 0
___ Some High School 1
___ High School Graduate 2
___ Some College 3
___ College Graduate 4
___ Unknown 9
Specify _____

Communication of Needs:
___ Verbally, English 0
___ Verbally, Other Language 1
Specify _____
___ Sign Language/Gestures/Device 2
___ Does Not Communicate 3
Hearing Impaired? _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name of Primary Physician: _____ **Phone:** _____

Address: _____

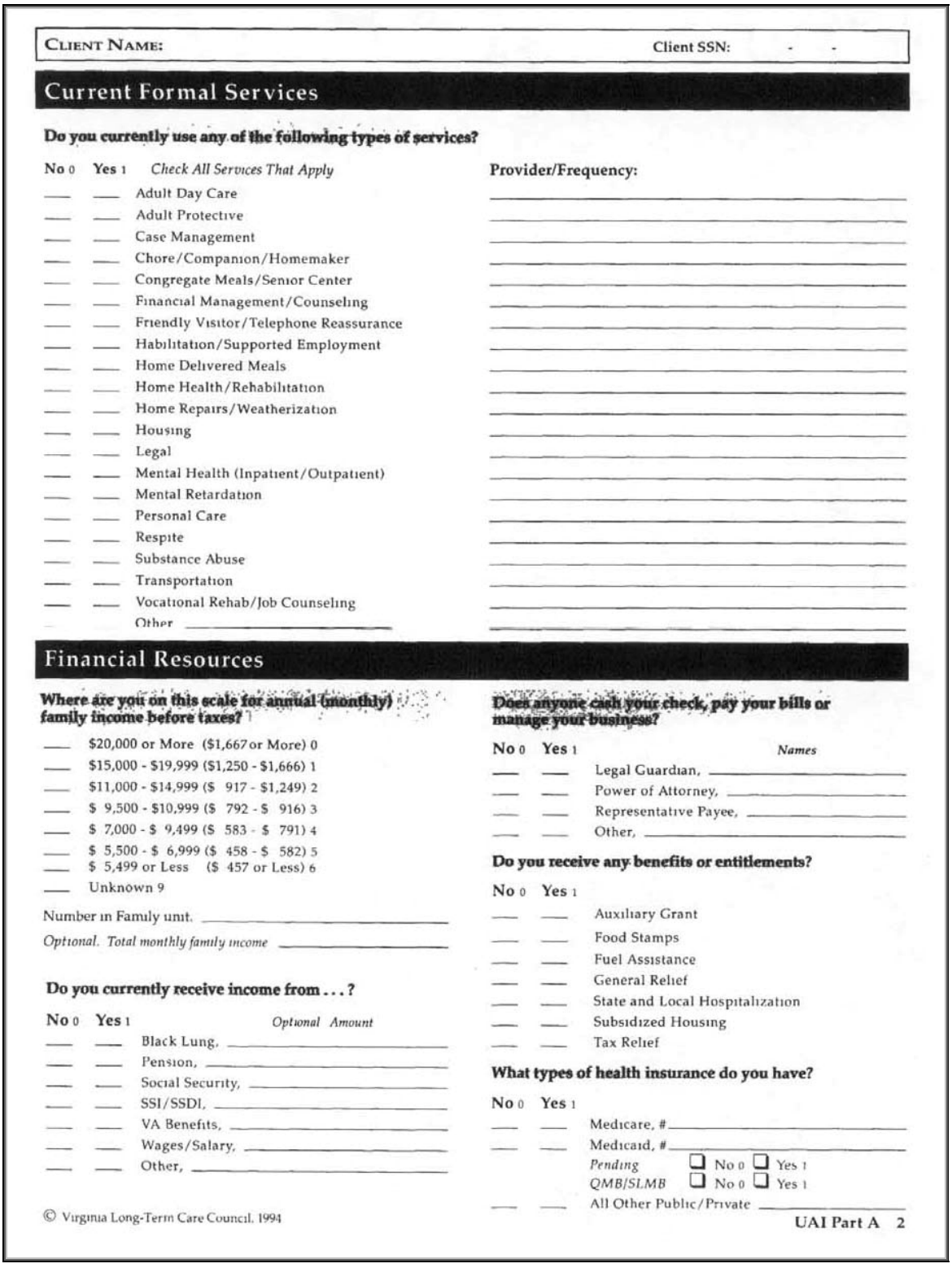
Initial Contact

Who called: _____ (Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

© Virginia Long-Term Care Council, 1994 UAI Part A 1

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*Check All Services That Apply*	Provider/Frequency:
___	___	Adult Day Care	
___	___	Adult Protective	
___	___	Case Management	
___	___	Chore/Companion/Homemaker	
___	___	Congregate Meals/Senior Center	
___	___	Financial Management/Counseling	
___	___	Friendly Visitor/Telephone Reassurance	
___	___	Habilitation/Supported Employment	
___	___	Home Delivered Meals	
___	___	Home Health/Rehabilitation	
___	___	Home Repairs/Weatherization	
___	___	Housing	
___	___	Legal	
___	___	Mental Health (Inpatient/Outpatient)	
___	___	Mental Retardation	
___	___	Personal Care	
___	___	Respite	
___	___	Substance Abuse	
___	___	Transportation	
___	___	Vocational Rehab/Job Counseling	
		Other ___	

Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

___ $20,000 or More ($1,667 or More) 0
___ $15,000 - $19,999 ($1,250 - $1,666) 1
___ $11,000 - $14,999 ($ 917 - $1,249) 2
___ $ 9,500 - $10,999 ($ 792 - $ 916) 3
___ $ 7,000 - $ 9,499 ($ 583 - $ 791) 4
___ $ 5,500 - $ 6,999 ($ 458 - $ 582) 5
___ $ 5,499 or Less ($ 457 or Less) 6
___ Unknown 9

Number in Family unit. ___

Optional. Total monthly family income ___

Do you currently receive income from . . . ?

No 0	Yes 1	*Optional Amount*
___	___	Black Lung, ___
___	___	Pension, ___
___	___	Social Security, ___
___	___	SSI/SSDI, ___
___	___	VA Benefits, ___
___	___	Wages/Salary, ___
___	___	Other, ___

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1	*Names*
___	___	Legal Guardian, ___
___	___	Power of Attorney, ___
___	___	Representative Payee, ___
___	___	Other, ___

Do you receive any benefits or entitlements?

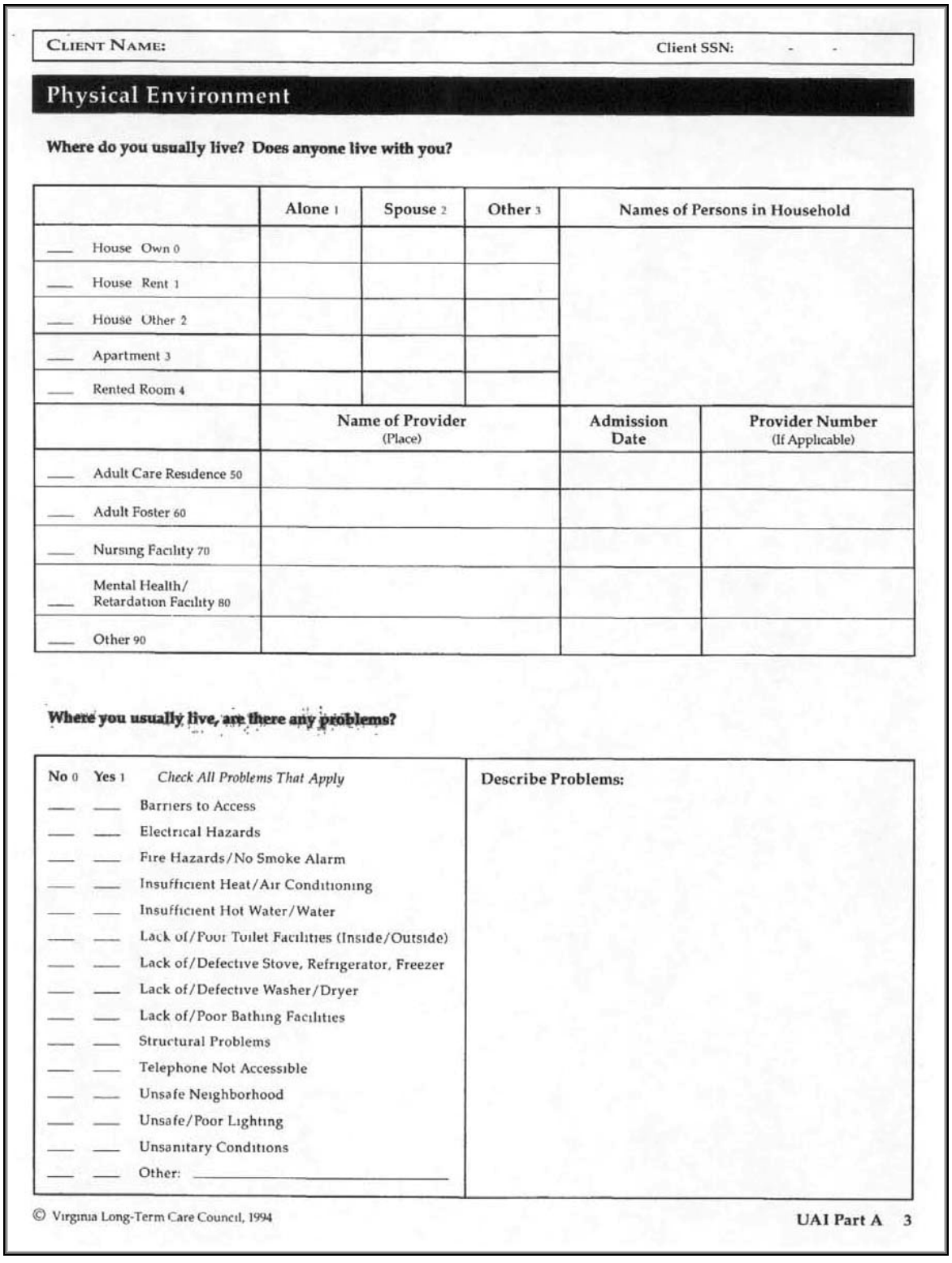
No 0	Yes 1	
___	___	Auxiliary Grant
___	___	Food Stamps
___	___	Fuel Assistance
___	___	General Relief
___	___	State and Local Hospitalization
___	___	Subsidized Housing
___	___	Tax Relief

What types of health insurance do you have?

No 0	Yes 1	
___	___	Medicare, # ___
___	___	Medicaid, # ___
		Pending ☐ No 0 ☐ Yes 1
		QMB/SLMB ☐ No 0 ☐ Yes 1
___	___	All Other Public/Private ___

UAI Part A 2

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
___ House Own 0				
___ House Rent 1				
___ House Other 2				
___ Apartment 3				
___ Rented Room 4				

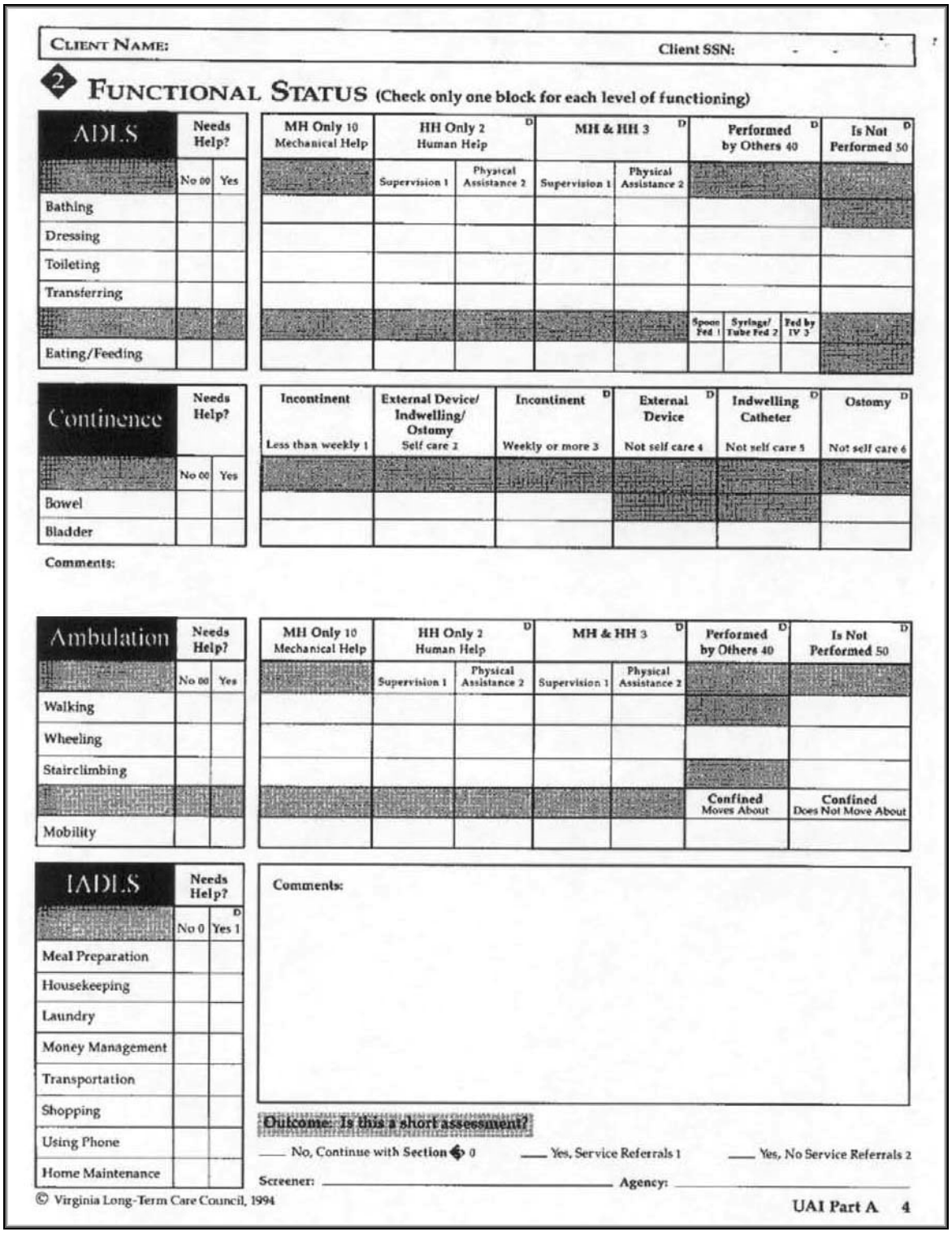
	Name of Provider (Place)	Admission Date	Provider Number (If Applicable)
___ Adult Care Residence 50			
___ Adult Foster 60			
___ Nursing Facility 70			
___ Mental Health/ Retardation Facility 80			
___ Other 90			

Where you usually live, are there any problems?

No 0	Yes 1	*Check All Problems That Apply*
___	___	Barriers to Access
___	___	Electrical Hazards
___	___	Fire Hazards/No Smoke Alarm
___	___	Insufficient Heat/Air Conditioning
___	___	Insufficient Hot Water/Water
___	___	Lack of/Poor Toilet Facilities (Inside/Outside)
___	___	Lack of/Defective Stove, Refrigerator, Freezer
___	___	Lack of/Defective Washer/Dryer
___	___	Lack of/Poor Bathing Facilities
___	___	Structural Problems
___	___	Telephone Not Accessible
___	___	Unsafe Neighborhood
___	___	Unsafe/Poor Lighting
___	___	Unsanitary Conditions
___	___	Other: _____

Describe Problems:

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40			Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding											

Continence	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
	No 00	Yes						
Bowel								
Bladder								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

IADLS	Needs Help?	
	No 0	Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

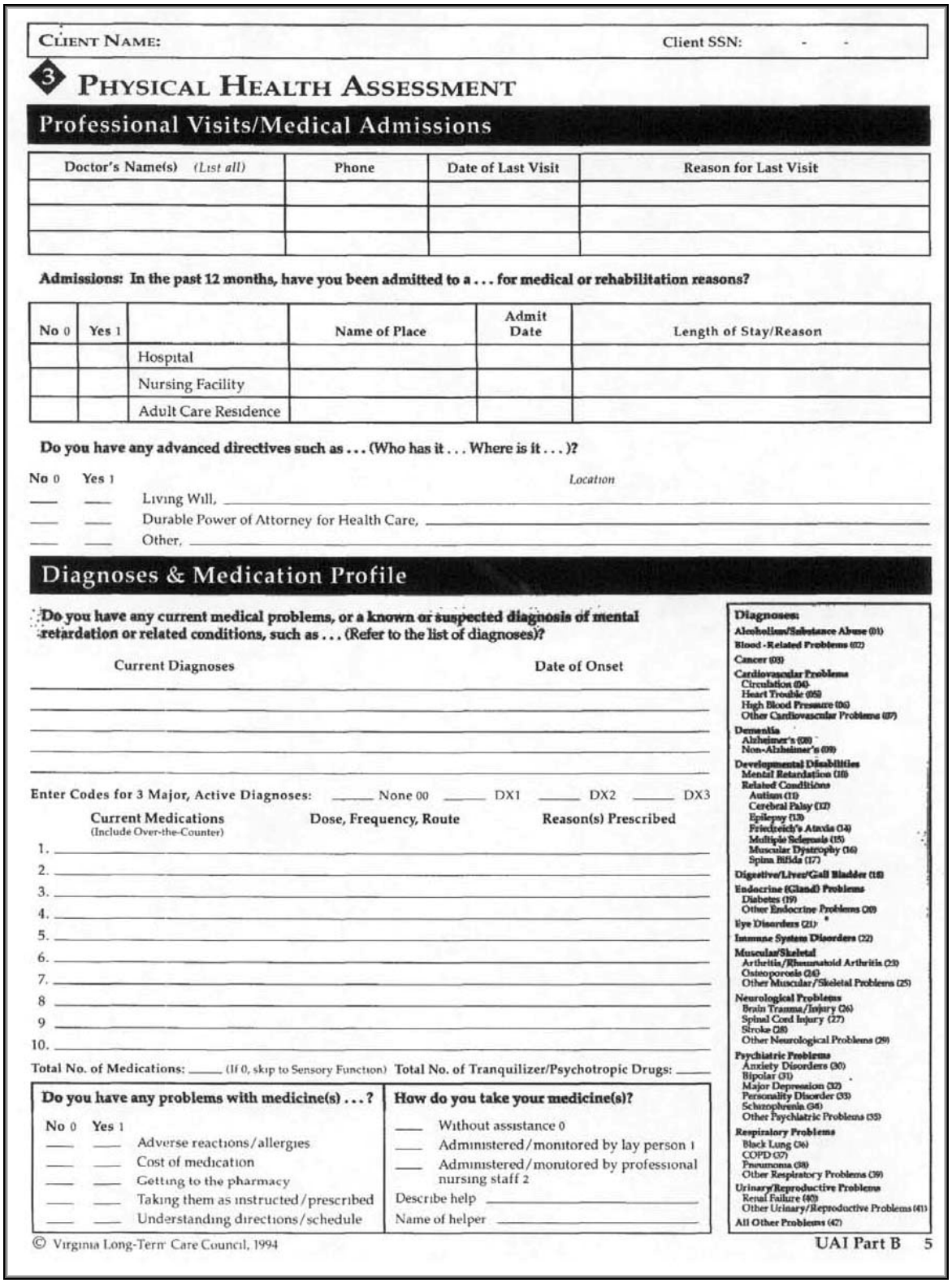
___ No, Continue with Section ➔ 0 ___ Yes, Service Referrals 1 ___ Yes, No Service Referrals 2

Screener: _____ Agency: _____

© Virginia Long-Term Care Council, 1994

UAI Part A 4

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advanced directives such as . . . (Who has it . . . Where is it . . .)?

No 0 Yes 1 *Location*

___ ___ Living Will, _____

___ ___ Durable Power of Attorney for Health Care, _____

___ ___ Other, _____

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)?

Current Diagnoses — Date of Onset

_____

_____

_____

_____

_____

Enter Codes for 3 Major, Active Diagnoses: ____ None 00 ____ DX1 ____ DX2 ____ DX3

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8		
9		
10.		

Total No. of Medications: ____ (If 0, skip to Sensory Function) Total No. of Tranquilizer/Psychotropic Drugs: ____

Do you have any problems with medicine(s) . . . ?

No 0 Yes 1

___ ___ Adverse reactions/allergies

___ ___ Cost of medication

___ ___ Getting to the pharmacy

___ ___ Taking them as instructed/prescribed

___ ___ Understanding directions/schedule

How do you take your medicine(s)?

___ Without assistance 0

___ Administered/monitored by lay person 1

___ Administered/monitored by professional nursing staff 2

Describe help _____

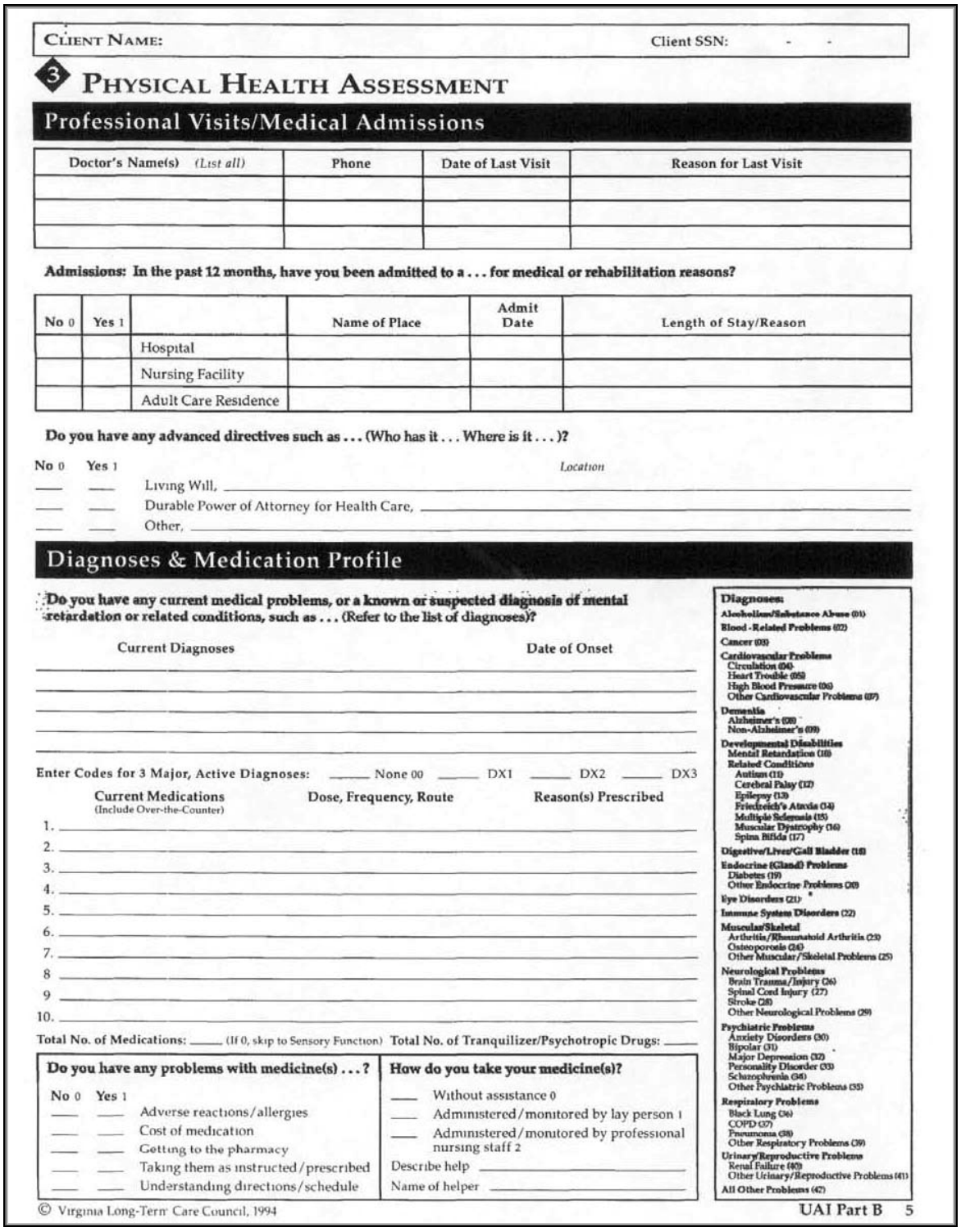
Name of helper _____

Diagnoses:

Alcoholism/Substance Abuse (01)
Blood-Related Problems (02)
Cancer (03)
Cardiovascular Problems
Circulation (04)
Heart Trouble (05)
High Blood Pressure (06)
Other Cardiovascular Problems (07)
Dementia
Alzheimer's (08)
Non-Alzheimer's (09)
Developmental Disabilities
Mental Retardation (10)
Related Conditions
Autism (11)
Cerebral Palsy (12)
Epilepsy (13)
Friedreich's Ataxia (14)
Multiple Sclerosis (15)
Muscular Dystrophy (16)
Spina Bifida (17)
Digestive/Liver/Gall Bladder (18)
Endocrine (Gland) Problems
Diabetes (19)
Other Endocrine Problems (20)
Eye Disorders (21)
Immune System Disorders (22)
Muscular/Skeletal
Arthritis/Rheumatoid Arthritis (23)
Osteoporosis (24)
Other Muscular/Skeletal Problems (25)
Neurological Problems
Brain Trauma/Injury (26)
Spinal Cord Injury (27)
Stroke (28)
Other Neurological Problems (29)
Psychiatric Problems
Anxiety Disorders (30)
Bipolar (31)
Major Depression (32)
Personality Disorder (33)
Schizophrenia (34)
Other Psychiatric Problems (35)
Respiratory Problems
Black Lung (36)
COPD (37)
Pneumonia (38)
Other Respiratory Problems (39)
Urinary/Reproductive Problems
Renal Failure (40)
Other Urinary/Reproductive Problems (41)
All Other Problems (42)

UAI Part B 5

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advanced directives such as . . . (Who has it . . . Where is it . . .)?

No 0	Yes 1		*Location*
___	___	Living Will,	
___	___	Durable Power of Attorney for Health Care,	
___	___	Other,	

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)?

Current Diagnoses — Date of Onset

Enter Codes for 3 Major, Active Diagnoses: ___ None 00 ___ DX1 ___ DX2 ___ DX3

	Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8			
9			
10.			

Total No. of Medications: ___ (If 0, skip to Sensory Function) Total No. of Tranquilizer/Psychotropic Drugs: ___

Do you have any problems with medicine(s) . . . ?

No 0	Yes 1	
___	___	Adverse reactions/allergies
___	___	Cost of medication
___	___	Getting to the pharmacy
___	___	Taking them as instructed/prescribed
___	___	Understanding directions/schedule

How do you take your medicine(s)?

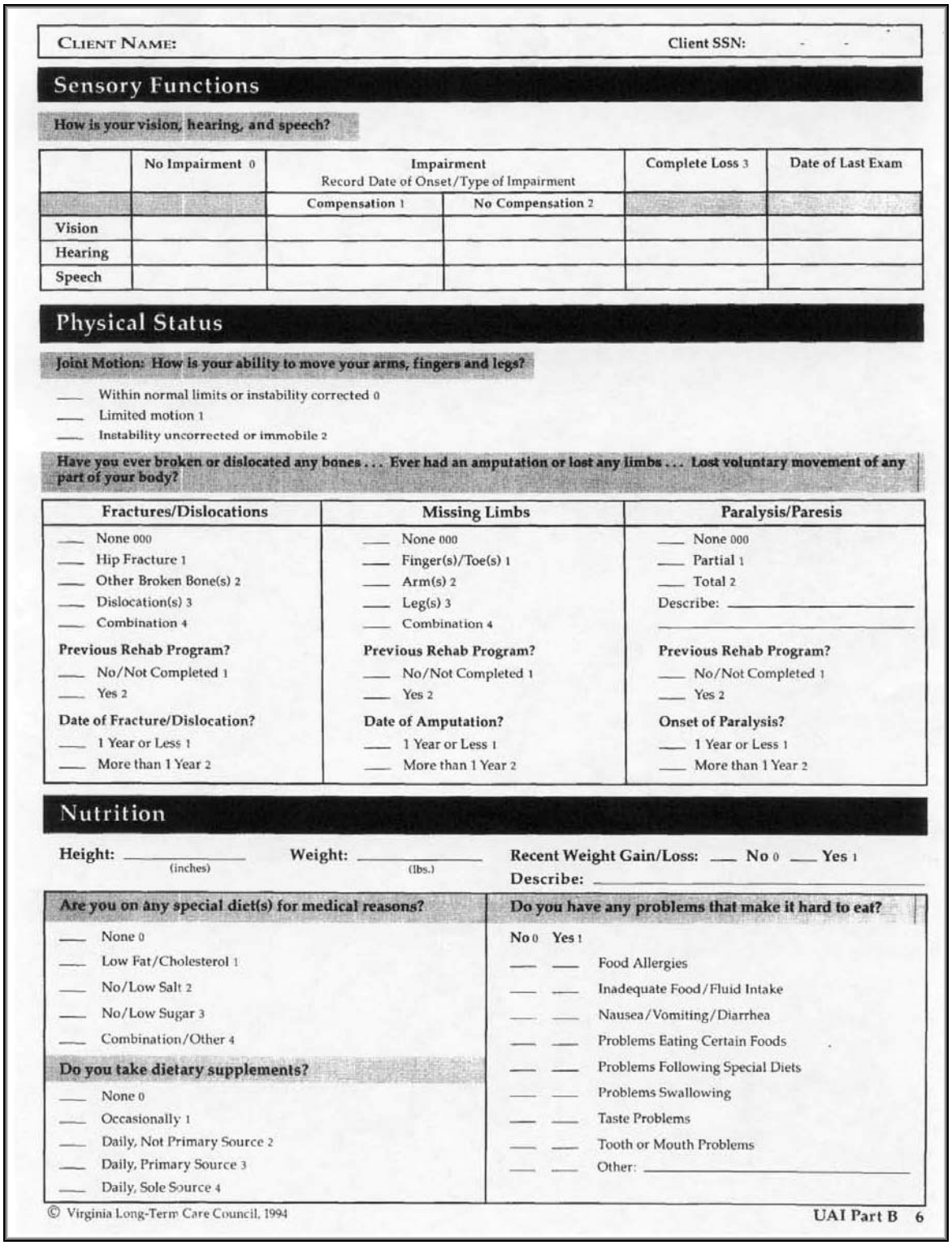
___ Without assistance 0
___ Administered/monitored by lay person 1
___ Administered/monitored by professional nursing staff 2

Describe help ___
Name of helper ___

Diagnoses:
Alcoholism/Substance Abuse (01)
Blood-Related Problems (02)
Cancer (03)
Cardiovascular Problems
Circulation (04)
Heart Trouble (05)
High Blood Pressure (06)
Other Cardiovascular Problems (07)
Dementia
Alzheimer's (08)
Non-Alzheimer's (09)
Developmental Disabilities
Mental Retardation (10)
Related Conditions
Autism (11)
Cerebral Palsy (12)
Epilepsy (13)
Friedreich's Ataxia (14)
Multiple Sclerosis (15)
Muscular Dystrophy (16)
Spina Bifida (17)
Digestive/Liver/Gall Bladder (18)
Endocrine (Gland) Problems
Diabetes (19)
Other Endocrine Problems (20)
Eye Disorders (21)
Immune System Disorders (22)
Muscular/Skeletal
Arthritis/Rheumatoid Arthritis (23)
Osteoporosis (24)
Other Muscular/Skeletal Problems (25)
Neurological Problems
Brain Trauma/Injury (26)
Spinal Cord Injury (27)
Stroke (28)
Other Neurological Problems (29)
Psychiatric Problems
Anxiety Disorders (30)
Bipolar (31)
Major Depression (32)
Personality Disorder (33)
Schizophrenia (34)
Other Psychiatric Problems (35)
Respiratory Problems
Black Lung (36)
COPD (37)
Pneumonia (38)
Other Respiratory Problems (39)
Urinary/Reproductive Problems
Renal Failure (40)
Other Urinary/Reproductive Problems (41)
All Other Problems (42)

© Virginia Long-Term Care Council, 1994 UAI Part B 5

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment Record Date of Onset/Type of Impairment		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
___ None 000	___ None 000	___ None 000
___ Hip Fracture 1	___ Finger(s)/Toe(s) 1	___ Partial 1
___ Other Broken Bone(s) 2	___ Arm(s) 2	___ Total 2
___ Dislocation(s) 3	___ Leg(s) 3	Describe: _____
___ Combination 4	___ Combination 4	_____
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
___ No/Not Completed 1	___ No/Not Completed 1	___ No/Not Completed 1
___ Yes 2	___ Yes 2	___ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
___ 1 Year or Less 1	___ 1 Year or Less 1	___ 1 Year or Less 1
___ More than 1 Year 2	___ More than 1 Year 2	___ More than 1 Year 2

Nutrition

Height: _____ (inches) **Weight:** _____ (lbs.) **Recent Weight Gain/Loss:** ___ No 0 ___ Yes 1
Describe: _____

Are you on any special diet(s) for medical reasons?

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

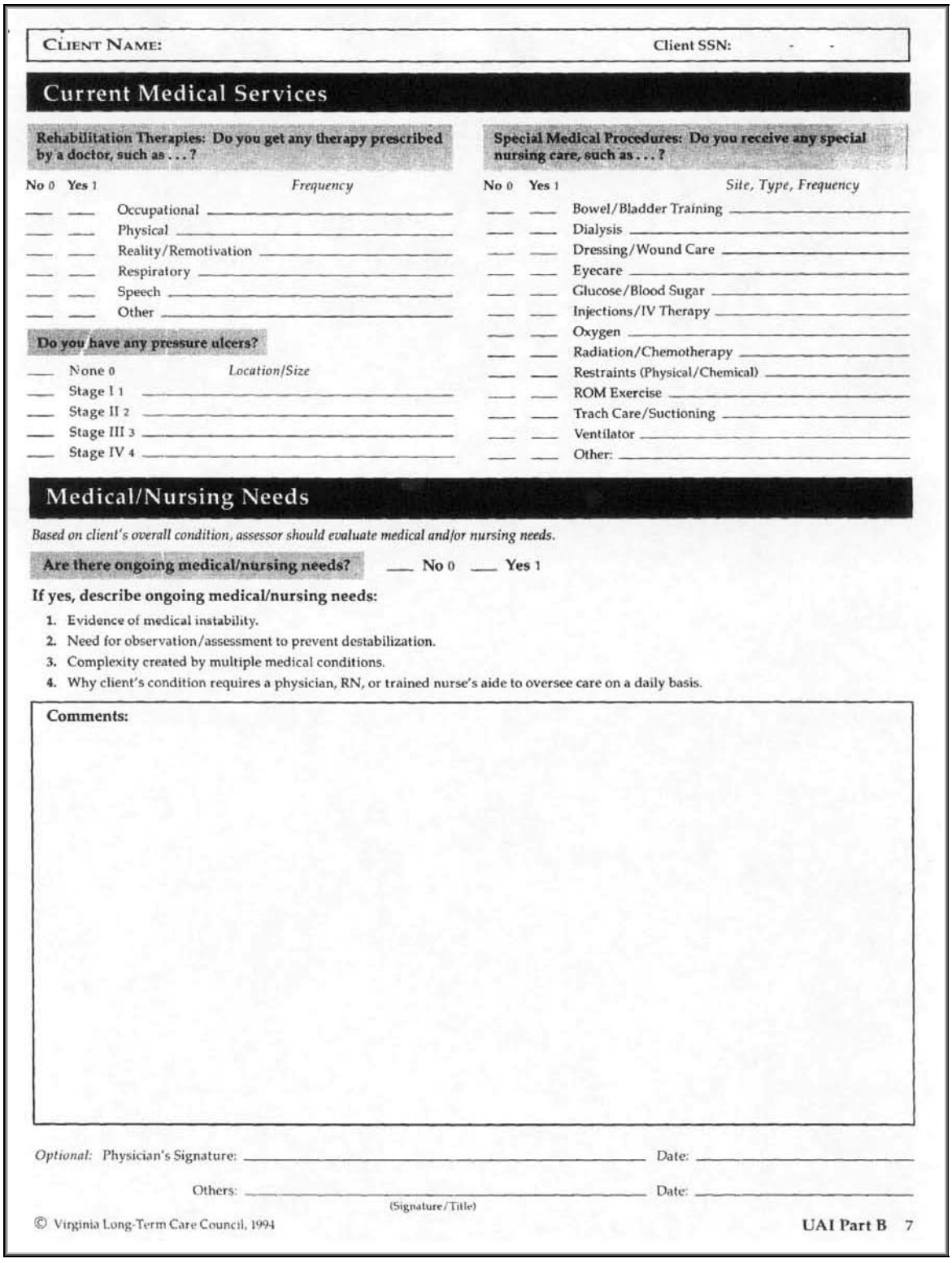
Do you take dietary supplements?

___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
___	___	Food Allergies
___	___	Inadequate Food/Fluid Intake
___	___	Nausea/Vomiting/Diarrhea
___	___	Problems Eating Certain Foods
___	___	Problems Following Special Diets
___	___	Problems Swallowing
___	___	Taste Problems
___	___	Tooth or Mouth Problems
___	___	Other: _____

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . ?

No 0	Yes 1		Frequency
___	___	Occupational	
___	___	Physical	
___	___	Reality/Remotivation	
___	___	Respiratory	
___	___	Speech	
___	___	Other	

Do you have any pressure ulcers?

		Location/Size
___	None 0	
___	Stage I 1	
___	Stage II 2	
___	Stage III 3	
___	Stage IV 4	

Special Medical Procedures: Do you receive any special nursing care, such as . . . ?

No 0	Yes 1		Site, Type, Frequency
___	___	Bowel/Bladder Training	
___	___	Dialysis	
___	___	Dressing/Wound Care	
___	___	Eyecare	
___	___	Glucose/Blood Sugar	
___	___	Injections/IV Therapy	
___	___	Oxygen	
___	___	Radiation/Chemotherapy	
___	___	Restraints (Physical/Chemical)	
___	___	ROM Exercise	
___	___	Trach Care/Suctioning	
___	___	Ventilator	
___	___	Other:	

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ___ No 0 ___ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

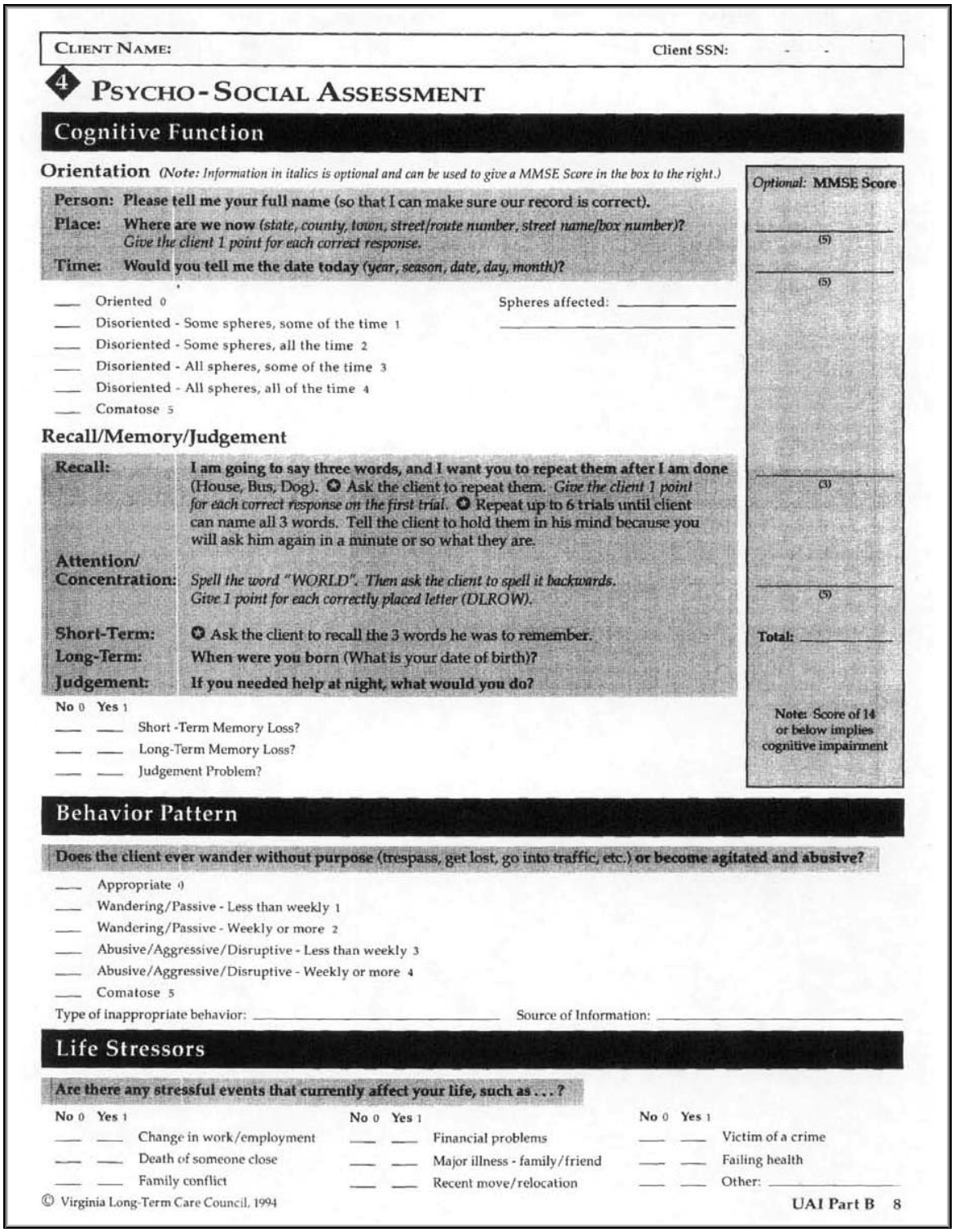
Comments:

Optional: Physician's Signature: _____ Date: _____

Others: _____ Date: _____
(Signature/Title)

UAI Part B 7

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: **Please tell me your full name** (so that I can make sure our record is correct).

Place: **Where are we now** *(state, county, town, street/route number, street name/box number)?* *Give the client 1 point for each correct response.*

Time: **Would you tell me the date today** *(year, season, date, day, month)?*

Optional: **MMSE Score**

(5)

(5)

(3)

(5)

Total: _____

Note: Score of 14 or below implies cognitive impairment

___ Oriented 0

___ Disoriented - Some spheres, some of the time 1

___ Disoriented - Some spheres, all the time 2

___ Disoriented - All spheres, some of the time 3

___ Disoriented - All spheres, all of the time 4

___ Comatose 5

Spheres affected: _____

Recall/Memory/Judgement

Recall: **I am going to say three words, and I want you to repeat them after I am done** (House, Bus, Dog). ✪ Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* ✪ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: ✪ Ask the client to recall the 3 words he was to remember.

Long-Term: **When were you born** (What is your date of birth)?

Judgement: **If you needed help at night, what would you do?**

No 0	Yes 1	
___	___	Short -Term Memory Loss?
___	___	Long-Term Memory Loss?
___	___	Judgement Problem?

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) **or become agitated and abusive?**

___ Appropriate 0

___ Wandering/Passive - Less than weekly 1

___ Wandering/Passive - Weekly or more 2

___ Abusive/Aggressive/Disruptive - Less than weekly 3

___ Abusive/Aggressive/Disruptive - Weekly or more 4

___ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
___	___	Change in work/employment	___	___	Financial problems	___	___	Victim of a crime
___	___	Death of someone close	___	___	Major illness - family/friend	___	___	Failing health
___	___	Family conflict	___	___	Recent move/relocation	___	___	Other: _____

UAI Part B 8

Sample Virginia Uniform Assessment Instrument

CLIENT NAME: Client SSN: - -

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you didn't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living . . . or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite . . . that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1 *Describe*

___ ___ Solitary Activities, _____

___ ___ With Friends/Family, _____

___ ___ With Groups/Clubs, _____

___ ___ Religious Activities, _____

How often do you talk with your children, family or friends, either during a visit or over the phone?

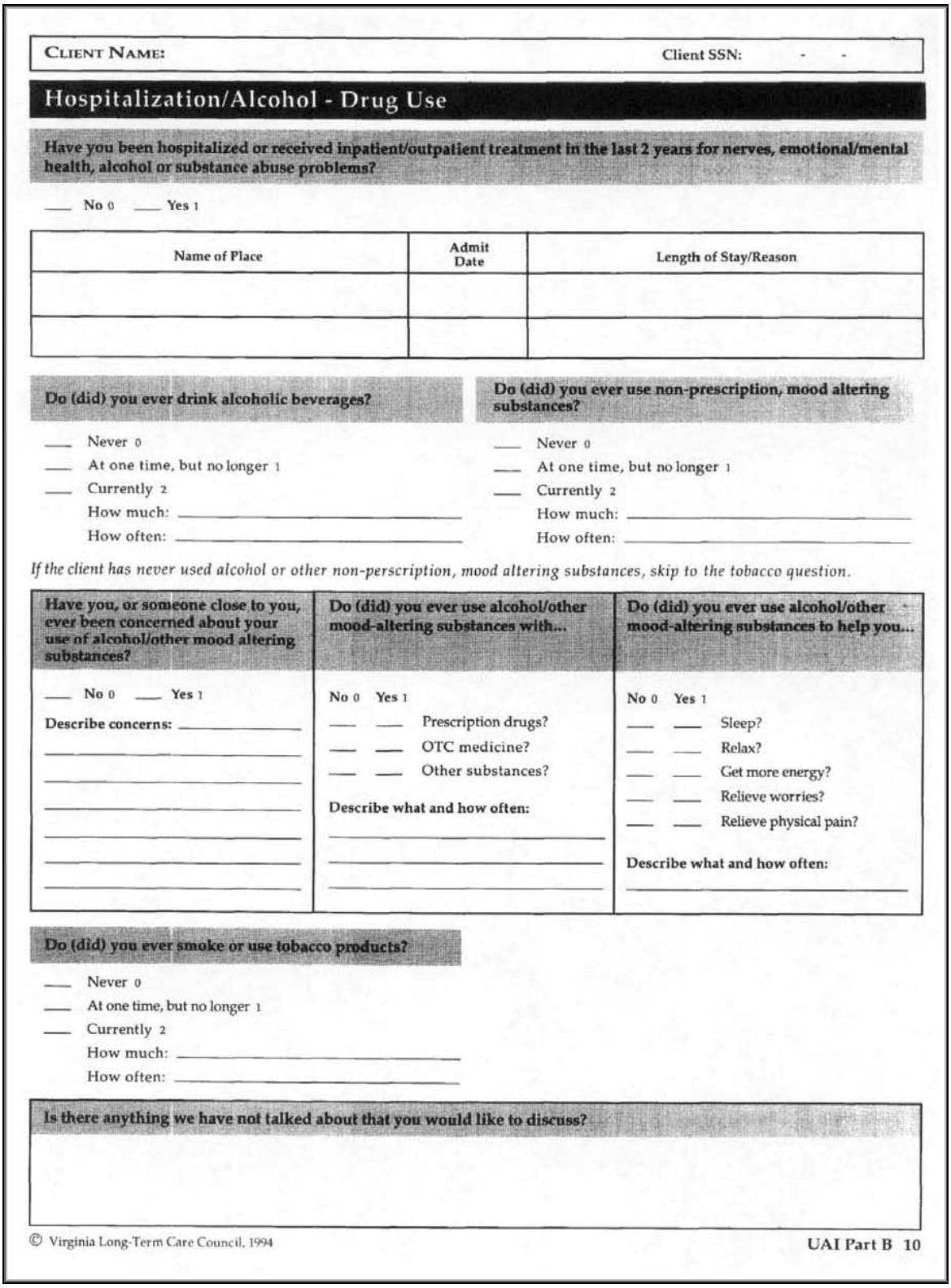
Children	Other Family	Friends/Neighbors
___ No Children 0	___ No Other Family 0	___ No Friends/Neighbors 0
___ Daily 1	___ Daily 1	___ Daily 1
___ Weekly 2	___ Weekly 2	___ Weekly 2
___ Monthly 3	___ Monthly 3	___ Monthly 3
___ Less than Monthly 4	___ Less than Monthly 4	___ Less than Monthly 4
___ Never 5	___ Never 5	___ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

___ No 0 ___ Yes 1

UAI Part B 9

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

___ No 0 ___ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-perscription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?

___ No 0 ___ Yes 1
Describe concerns: _____

Do (did) you ever use alcohol/other mood-altering substances with...

No 0 Yes 1
___ ___ Prescription drugs?
___ ___ OTC medicine?
___ ___ Other substances?

Describe what and how often:

Do (did) you ever use alcohol/other mood-altering substances to help you...

No 0 Yes 1
___ ___ Sleep?
___ ___ Relax?
___ ___ Get more energy?
___ ___ Relieve worries?
___ ___ Relieve physical pain?

Describe what and how often:

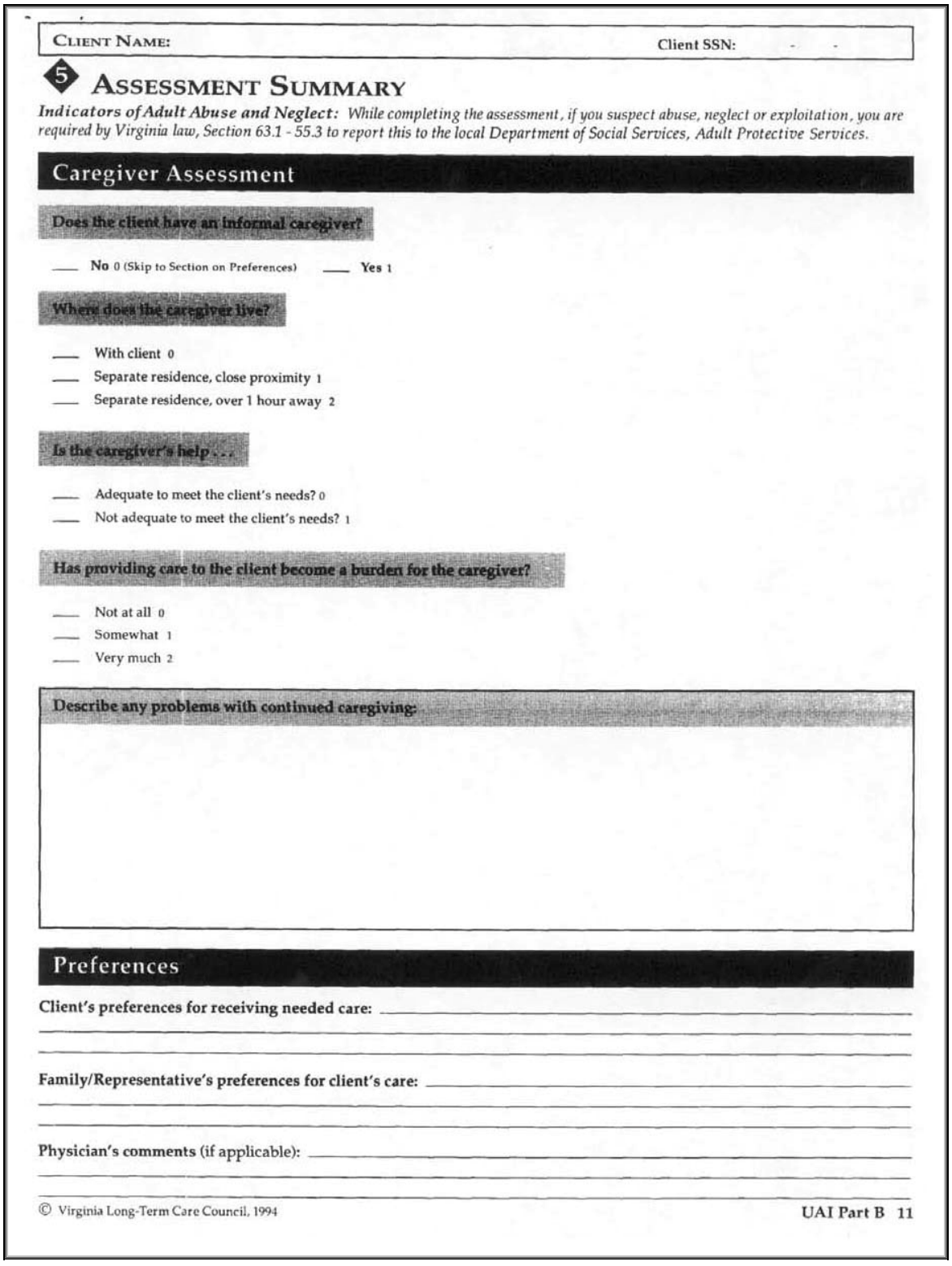
Do (did) you ever smoke or use tobacco products?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

UAI Part B 10

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

___ **No** 0 (Skip to Section on Preferences) ___ **Yes** 1

Where does the caregiver live?

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

Is the caregiver's help . . .

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

___ Not at all 0
___ Somewhat 1
___ Very much 2

Describe any problems with continued caregiving:

Preferences

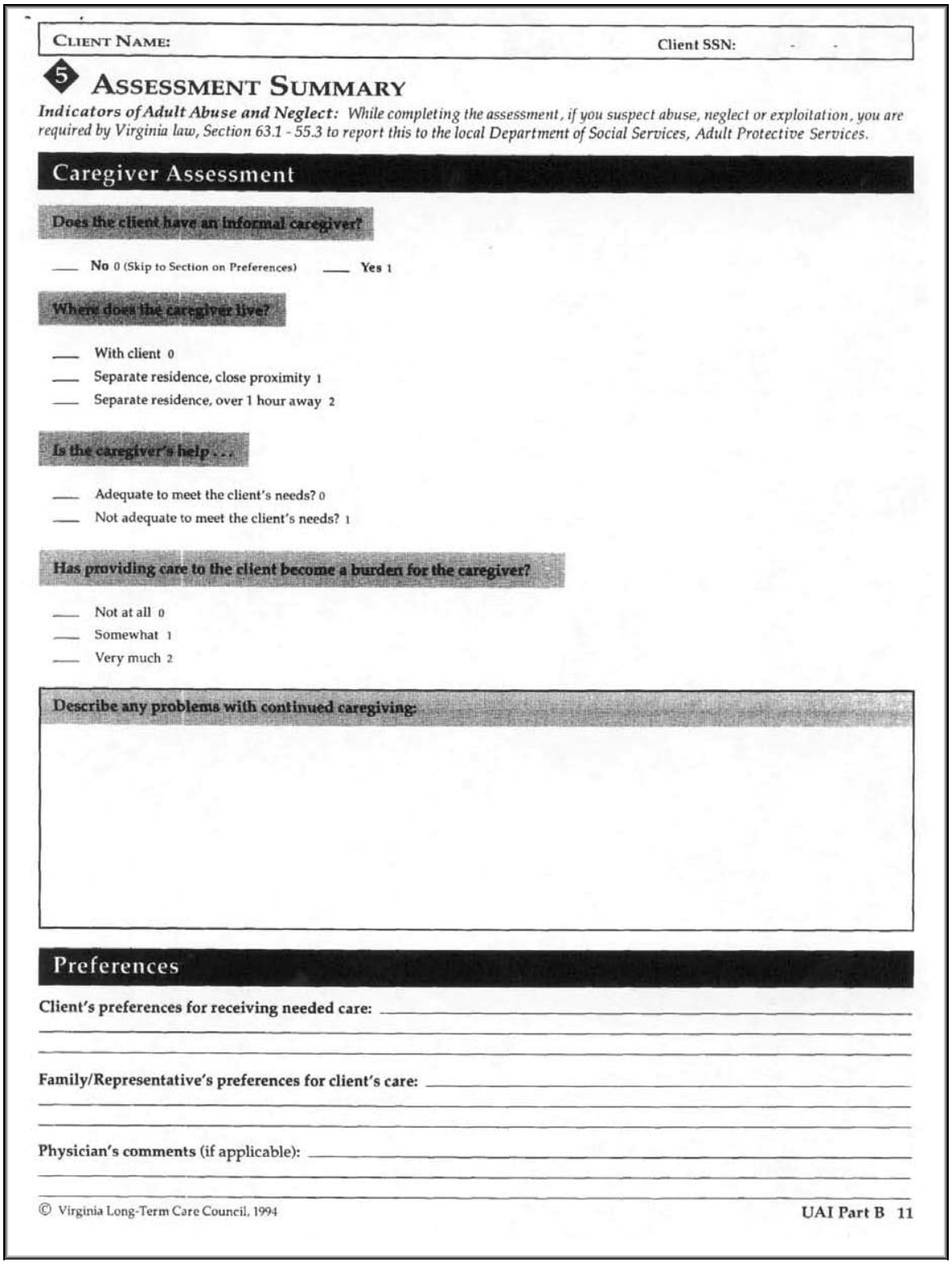
Client's preferences for receiving needed care: _____

Family/Representative's preferences for client's care: _____

Physician's comments (if applicable): _____

UAI Part B 11

Sample Virginia Uniform Assessment Instrument



CLIENT NAME: Client SSN: - -

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

___ **No** 0 (Skip to Section on Preferences) ___ **Yes** 1

Where does the caregiver live?

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

Is the caregiver's help . . .

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

___ Not at all 0
___ Somewhat 1
___ Very much 2

Describe any problems with continued caregiving:

Preferences

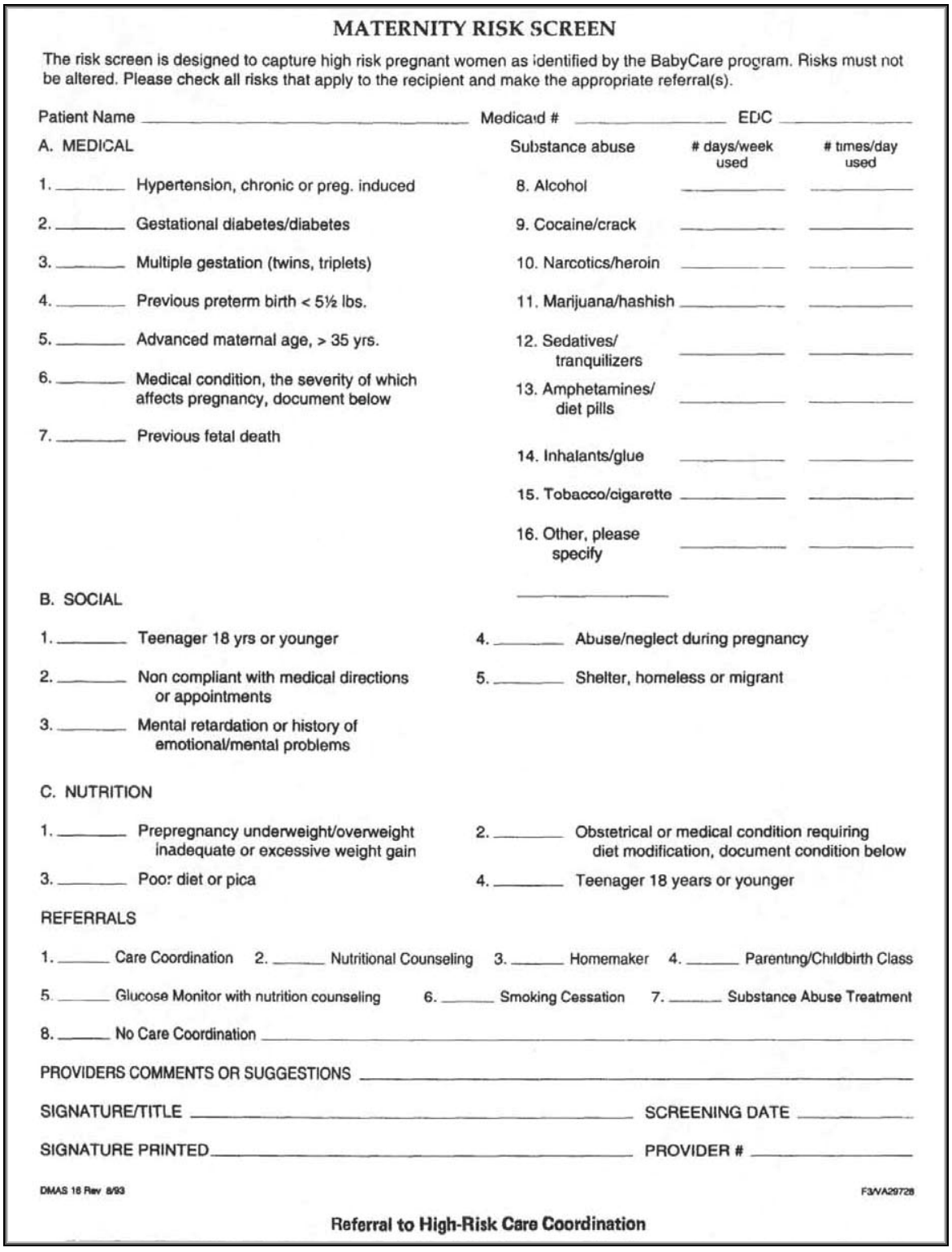
Client's preferences for receiving needed care: _____

Family/Representative's preferences for client's care: _____

Physician's comments (if applicable): _____

UAI Part B 11

Sample Virginia Uniform Assessment Instrument



MATERNITY RISK SCREEN

The risk screen is designed to capture high risk pregnant women as identified by the BabyCare program. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name _____ Medicaid # _____ EDC _____

A. MEDICAL

1. _____ Hypertension, chronic or preg. induced
2. _____ Gestational diabetes/diabetes
3. _____ Multiple gestation (twins, triplets)
4. _____ Previous preterm birth < 5½ lbs.
5. _____ Advanced maternal age, > 35 yrs.
6. _____ Medical condition, the severity of which affects pregnancy, document below
7. _____ Previous fetal death

Substance abuse	# days/week used	# times/day used
8. Alcohol		
9. Cocaine/crack		
10. Narcotics/heroin		
11. Marijuana/hashish		
12. Sedatives/ tranquilizers		
13. Amphetamines/ diet pills		
14. Inhalants/glue		
15. Tobacco/cigarette		
16. Other, please specify _____		

B. SOCIAL

1. _____ Teenager 18 yrs or younger
2. _____ Non compliant with medical directions or appointments
3. _____ Mental retardation or history of emotional/mental problems
4. _____ Abuse/neglect during pregnancy
5. _____ Shelter, homeless or migrant

C. NUTRITION

1. _____ Prepregnancy underweight/overweight inadequate or excessive weight gain
2. _____ Obstetrical or medical condition requiring diet modification, document condition below
3. _____ Poor diet or pica
4. _____ Teenager 18 years or younger

REFERRALS

1. _____ Care Coordination 2. _____ Nutritional Counseling 3. _____ Homemaker 4. _____ Parenting/Childbirth Class
5. _____ Glucose Monitor with nutrition counseling 6. _____ Smoking Cessation 7. _____ Substance Abuse Treatment
8. _____ No Care Coordination _____

PROVIDERS COMMENTS OR SUGGESTIONS _____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PROVIDER # _____

DMAS 18 Rev 8/93 F3/VA29728

Referral to High-Risk Care Coordination

Sample MICC Maternity Risk Screen

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT RISK SCREEN

Research supports the fact that indigent mothers and their high risk infants often need a combination of medical and non-medical services to assure positive infant health.
The risk screen is designed to capture high risk infants as identified by the Baby Care Program. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name: _____ VMAP ID#_____
Parent /Guardian Name: _____
Patient Address: _____

A. MEDICAL

__Diagnosed developmentally delayed/neurologically impaired

__Diagnosed medically significant genetic condition (including sickle cell disease)

__ Birth Weight 1750 grams (3lbs., 14 oz) or less

__Chronic illness

__Diagnosed with fetal alcohol syndrome (FAS)

__Medical high risk infant and pediatric care needed but not available 24 hours a day

__Medical condition(s) the severity of which requires care coordination (document medical condition below)

__Born exposed to an illegal drug in utero

__Failure to thrive of flattening of growth curve

B. SOCIAL

__Parent/guardian unable to communicate due to language barriers (e.g. non-English speaking, illiterate)

__Maternal absence (illness, incarceration, abandonment)

__Parental substance abuse/addition (only includes father if living in home)

__ Caregiver's handicap presents risk to infant (physical impaired, hearing impaired, vision impaired)

__Caregiver mental illness/mental retardation

__Shelter, homeless or migrant worker

__Mother 18 years or younger

__History of suspected abuse/or neglect

__Non compliant with follow-up visits/screening visits and medical direction for this infant.

C. NUTRITION

__ Congenial abnormalities affecting ability to feed or requiring special feeding techniques; poor sucking, severe or continuing diarrhea or vomiting; other conditions requiring diet modification.

__ Inadequate diet

D. REFERRAL

__Care Coordination

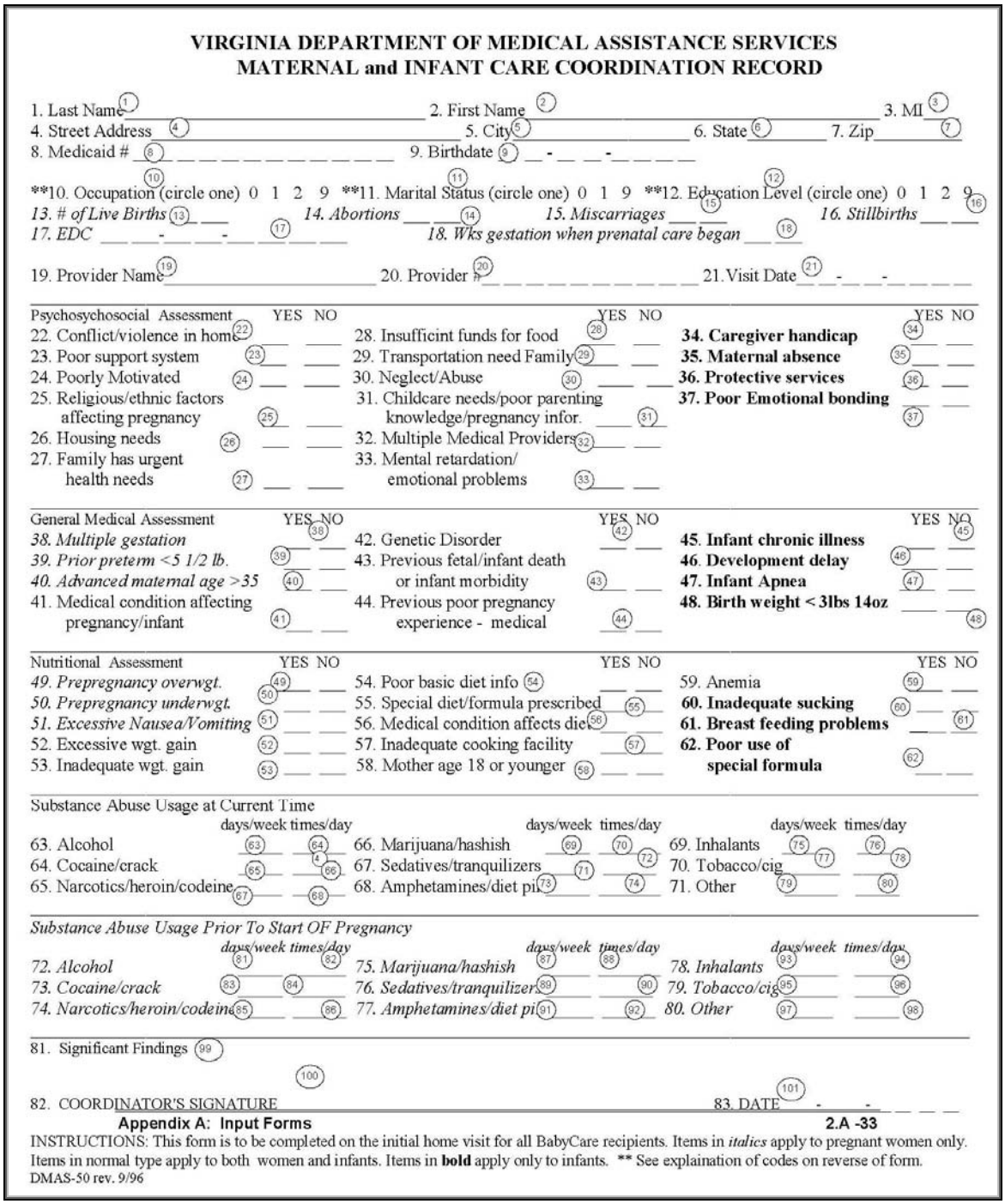
__No Care Coordination - What services will the recipient receive?_____

PROVIDER COMMENTS OR SUGGESTIONS_____

SIGNATURE/TITLE_____SCREENING DATE_____

SIGNATURE PRINTED PROVIDER #

Sample MICC Infant Risk Screen



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL and INFANT CARE COORDINATION RECORD

1. Last Name (1) _____ 2. First Name (2) _____ 3. MI (3) ___
4. Street Address (4) _____ 5. City (5) _____ 6. State (6) _____ 7. Zip (7) _____
8. Medicaid # (8) _ _ _ _ _ _ _ _ _ _ 9. Birthdate (9) _ _ - _ _ - _ _ _ _

**10. Occupation (10) (circle one) 0 1 2 9 **11. Marital Status (11) (circle one) 0 1 9 **12. Education Level (12) (circle one) 0 1 2 9
13. # of Live Births (13) ___ *14. Abortions (14) ___* *15. Miscarriages (15) ___* *16. Stillbirths (16) ___*
17. EDC (17) ___ ___ - ___ ___ - ___ ___ ___ *18. Wks gestation when prenatal care began (18) ___ ___*

19. Provider Name (19) _____ 20. Provider # (20) _ _ _ _ _ _ _ _ _ _ 21. Visit Date (21) _ _ - _ _ - _ _ _ _

Psychosychosocial Assessment	YES	NO		YES	NO		YES	NO
22. Conflict/violence in home (22)	___	___	28. Insufficint funds for food (28)	___	___	**34. Caregiver handicap (34)**	___	___
23. Poor support system (23)	___	___	29. Transportation need Family (29)	___	___	**35. Maternal absence (35)**	___	___
24. Poorly Motivated (24)	___	___	30. Neglect/Abuse (30)	___	___	**36. Protective services (36)**	___	___
25. Religious/ethnic factors affecting pregnancy (25)	___	___	31. Childcare needs/poor parenting knowledge/pregnancy infor. (31)	___	___	**37. Poor Emotional bonding (37)**	___	___
26. Housing needs (26)	___	___	32. Multiple Medical Providers (32)	___	___			
27. Family has urgent health needs (27)	___	___	33. Mental retardation/ emotional problems (33)	___	___			

General Medical Assessment	YES	NO		YES	NO		YES	NO
38. Multiple gestation (38)	___	___	42. Genetic Disorder (42)	___	___	**45. Infant chronic illness (45)**	___	___
39. Prior preterm <5 1/2 lb. (39)	___	___	43. Previous fetal/infant death or infant morbidity (43)	___	___	**46. Development delay (46)**	___	___
40. Advanced maternal age >35 (40)	___	___				**47. Infant Apnea (47)**	___	___
41. Medical condition affecting pregnancy/infant (41)	___	___	44. Previous poor pregnancy experience - medical (44)	___	___	**48. Birth weight < 3lbs 14oz (48)**	___	___

Nutritional Assessment	YES	NO		YES	NO		YES	NO
49. Prepregnancy overwgt. (49)	___	___	54. Poor basic diet info (54)	___	___	59. Anemia (59)	___	___
50. Prepregnancy underwgt. (50)	___	___	55. Special diet/formula prescribed (55)	___	___	**60. Inadequate sucking (60)**	___	___
51. Excessive Nausea/Vomiting (51)	___	___	56. Medical condition affects diet (56)	___	___	**61. Breast feeding problems (61)**	___	___
52. Excessive wgt. gain (52)	___	___	57. Inadequate cooking facility (57)	___	___	**62. Poor use of special formula (62)**	___	___
53. Inadequate wgt. gain (53)	___	___	58. Mother age 18 or younger (58)	___	___			

Substance Abuse Usage at Current Time

	days/week	times/day		days/week	times/day		days/week	times/day
63. Alcohol (63) (64)	___	___	66. Marijuana/hashish (69) (70)	___	___	69. Inhalants (75) (76)	___	___
64. Cocaine/crack (65) (66)	___	___	67. Sedatives/tranquilizers (71) (72)	___	___	70. Tobacco/cig (77) (78)	___	___
65. Narcotics/heroin/codeine (67) (68)	___	___	68. Amphetamines/diet pi (73) (74)	___	___	71. Other (79) (80)	___	___

Substance Abuse Usage Prior To Start OF Pregnancy

	days/week	*times/day*		*days/week*	*times/day*		*days/week*	*times/day*
72. Alcohol (81) (82)	___	___	*75. Marijuana/hashish (87) (88)*	___	___	*78. Inhalants (93) (94)*	___	___
73. Cocaine/crack (83) (84)	___	___	*76. Sedatives/tranquilizers (89) (90)*	___	___	*79. Tobacco/cig (95) (96)*	___	___
74. Narcotics/heroin/codeine (85) (86)	___	___	*77. Amphetamines/diet pi (91) (92)*	___	___	*80. Other (97) (98)*	___	___

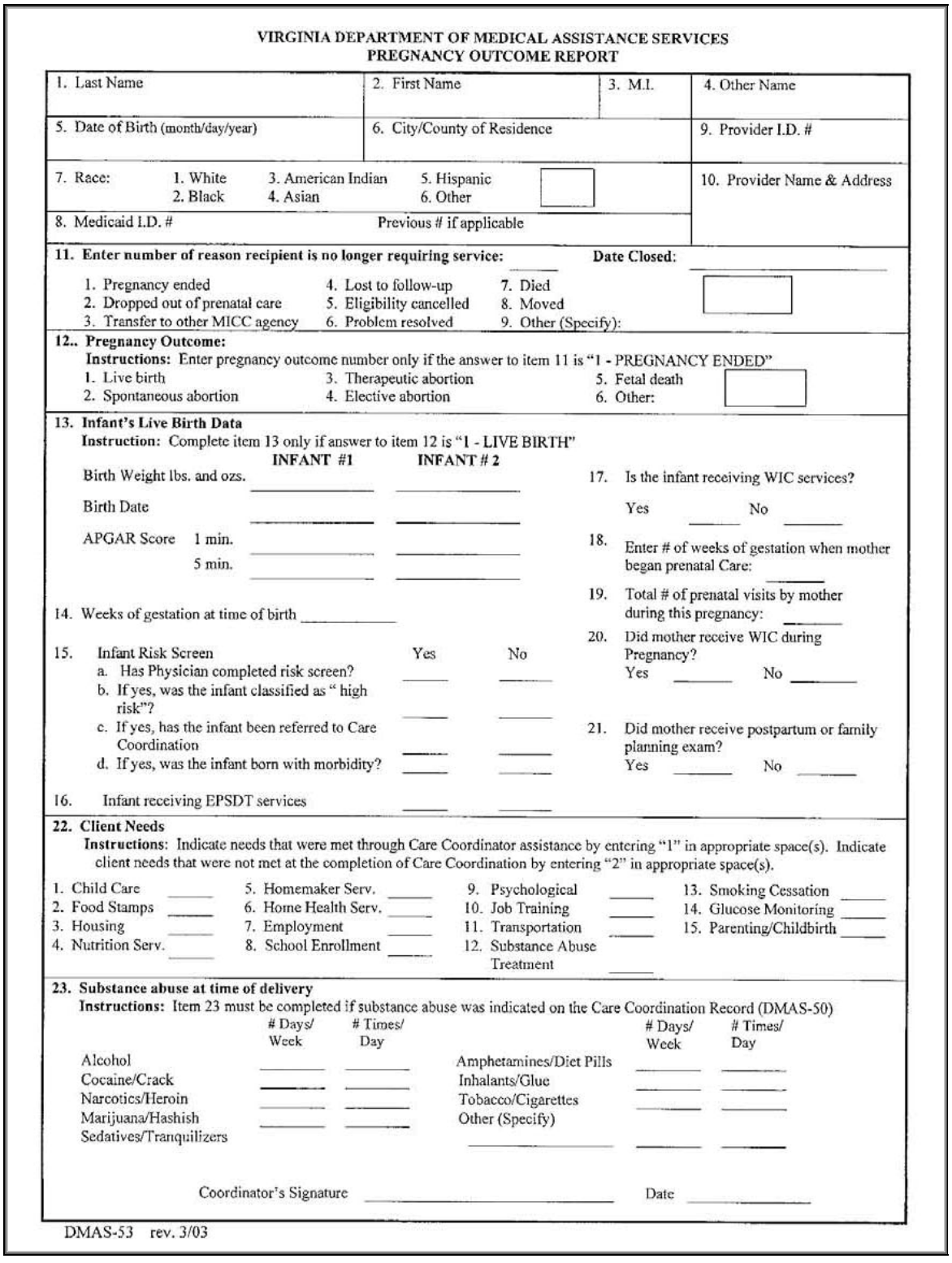
81. Significant Findings (99)

(100)

82. COORDINATOR'S SIGNATURE _____ 83. DATE (101) _ _ - _ _ - _ _ _ _

INSTRUCTIONS: This form is to be completed on the initial home visit for all BabyCare recipients. Items in *italics* apply to pregnant women only. Items in normal type apply to both women and infants. Items in **bold** apply only to infants. ** See explaination of codes on reverse of form.
DMAS-50 rev. 9/96

Sample VDMAS Maternal and Infant Care Coordination Record



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PREGNANCY OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (month/day/year)	6. City/County of Residence		9. Provider I.D. #
7. Race: 1. White 2. Black 3. American Indian 4. Asian 5. Hispanic 6. Other			10. Provider Name & Address
8. Medicaid I.D. # Previous # if applicable			

11. Enter number of reason recipient is no longer requiring service: ____ **Date Closed:** _____

1. Pregnancy ended
2. Dropped out of prenatal care
3. Transfer to other MICC agency
4. Lost to follow-up
5. Eligibility cancelled
6. Problem resolved
7. Died
8. Moved
9. Other (Specify):

12.. Pregnancy Outcome:
Instructions: Enter pregnancy outcome number only if the answer to item 11 is "1 - PREGNANCY ENDED"

1. Live birth
2. Spontaneous abortion
3. Therapeutic abortion
4. Elective abortion
5. Fetal death
6. Other:

13. Infant's Live Birth Data
Instruction: Complete item 13 only if answer to item 12 is "1 - LIVE BIRTH"

	INFANT #1	INFANT # 2
Birth Weight lbs. and ozs.		
Birth Date		
APGAR Score 1 min.		
5 min.		

14. Weeks of gestation at time of birth _____

15. Infant Risk Screen	Yes	No
a. Has Physician completed risk screen?		
b. If yes, was the infant classified as " high risk"?		
c. If yes, has the infant been referred to Care Coordination		
d. If yes, was the infant born with morbidity?		
16. Infant receiving EPSDT services		

17. Is the infant receiving WIC services?
Yes _____ No _____

18. Enter # of weeks of gestation when mother began prenatal Care: _____

19. Total # of prenatal visits by mother during this pregnancy: _____

20. Did mother receive WIC during Pregnancy?
Yes _____ No _____

21. Did mother receive postpartum or family planning exam?
Yes _____ No _____

22. Client Needs
Instructions: Indicate needs that were met through Care Coordinator assistance by entering "1" in appropriate space(s). Indicate client needs that were not met at the completion of Care Coordination by entering "2" in appropriate space(s).

1. Child Care
2. Food Stamps
3. Housing
4. Nutrition Serv.
5. Homemaker Serv.
6. Home Health Serv.
7. Employment
8. School Enrollment
9. Psychological
10. Job Training
11. Transportation
12. Substance Abuse Treatment
13. Smoking Cessation
14. Glucose Monitoring
15. Parenting/Childbirth

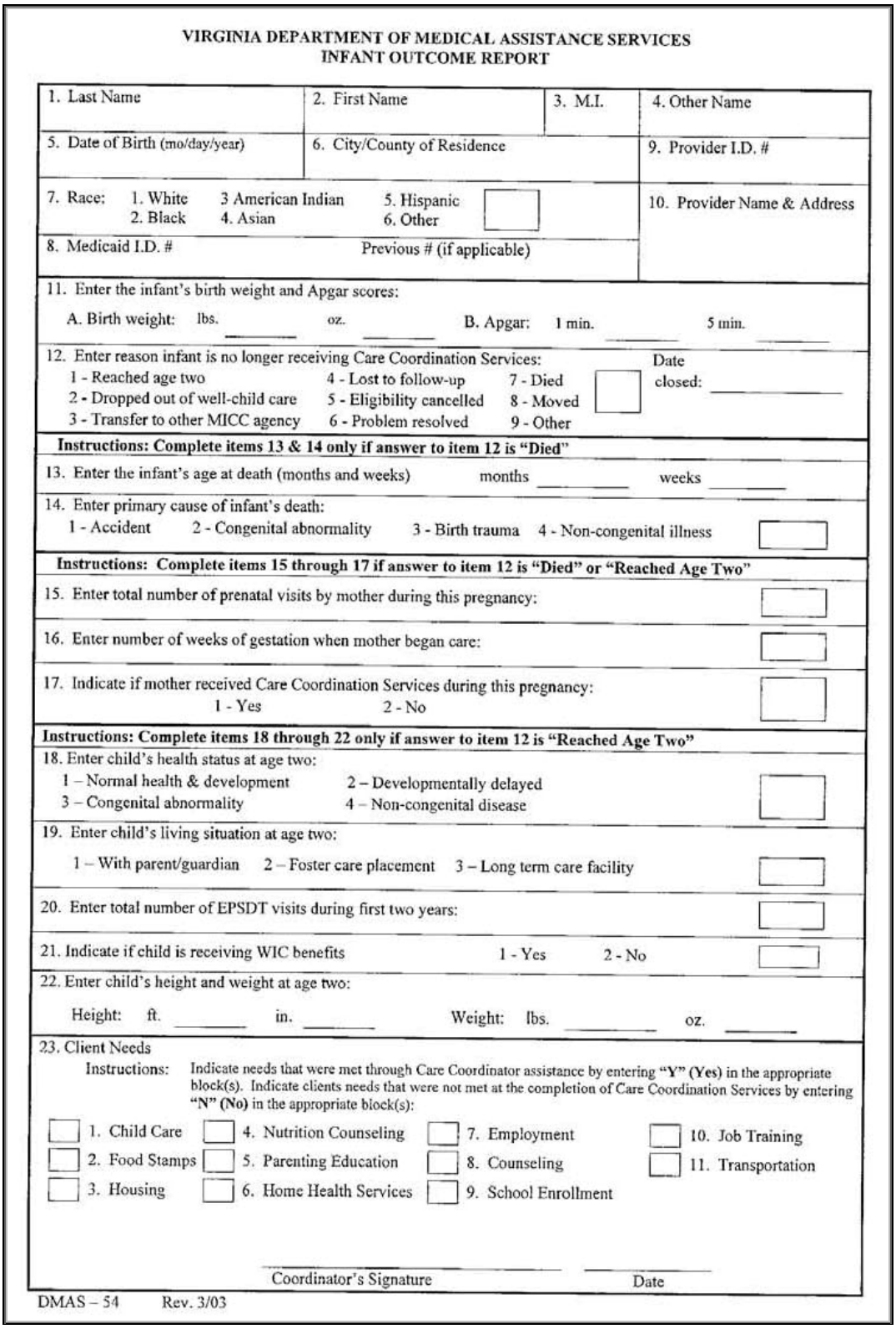
23. Substance abuse at time of delivery
Instructions: Item 23 must be completed if substance abuse was indicated on the Care Coordination Record (DMAS-50)

	# Days/ Week	# Times/ Day		# Days/ Week	# Times/ Day
Alcohol			Amphetamines/Diet Pills		
Cocaine/Crack			Inhalants/Glue		
Narcotics/Heroin			Tobacco/Cigarettes		
Marijuana/Hashish			Other (Specify)		
Sedatives/Tranquilizers					

Coordinator's Signature _____ Date _____

DMAS-53 rev. 3/03

Sample VDMAS Pregnancy Outcome Report



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (mo/day/year)	6. City/County of Residence		9. Provider I.D. #
7. Race: 1. White 2. Black 3 American Indian 4. Asian 5. Hispanic 6. Other			10. Provider Name & Address
8. Medicaid I.D. # Previous # (if applicable)			

11. Enter the infant's birth weight and Apgar scores:
A. Birth weight: lbs. _____ oz. _____ B. Apgar: 1 min. _____ 5 min. _____

12. Enter reason infant is no longer receiving Care Coordination Services: Date closed: _____
1 - Reached age two; 2 - Dropped out of well-child care; 3 - Transfer to other MICC agency; 4 - Lost to follow-up; 5 - Eligibility cancelled; 6 - Problem resolved; 7 - Died; 8 - Moved; 9 - Other

Instructions: Complete items 13 & 14 only if answer to item 12 is "Died"

13. Enter the infant's age at death (months and weeks) months _____ weeks _____

14. Enter primary cause of infant's death:
1 - Accident 2 - Congenital abnormality 3 - Birth trauma 4 - Non-congenital illness

Instructions: Complete items 15 through 17 if answer to item 12 is "Died" or "Reached Age Two"

15. Enter total number of prenatal visits by mother during this pregnancy:

16. Enter number of weeks of gestation when mother began care:

17. Indicate if mother received Care Coordination Services during this pregnancy:
1 - Yes 2 - No

Instructions: Complete items 18 through 22 only if answer to item 12 is "Reached Age Two"

18. Enter child's health status at age two:
1 – Normal health & development 2 – Developmentally delayed
3 – Congenital abnormality 4 – Non-congenital disease

19. Enter child's living situation at age two:
1 – With parent/guardian 2 – Foster care placement 3 – Long term care facility

20. Enter total number of EPSDT visits during first two years:

21. Indicate if child is receiving WIC benefits 1 - Yes 2 - No

22. Enter child's height and weight at age two:
Height: ft. _____ in. _____ Weight: lbs. _____ oz. _____

23. Client Needs
Instructions: Indicate needs that were met through Care Coordinator assistance by entering **"Y" (Yes)** in the appropriate block(s). Indicate clients needs that were not met at the completion of Care Coordination Services by entering **"N" (No)** in the appropriate block(s):

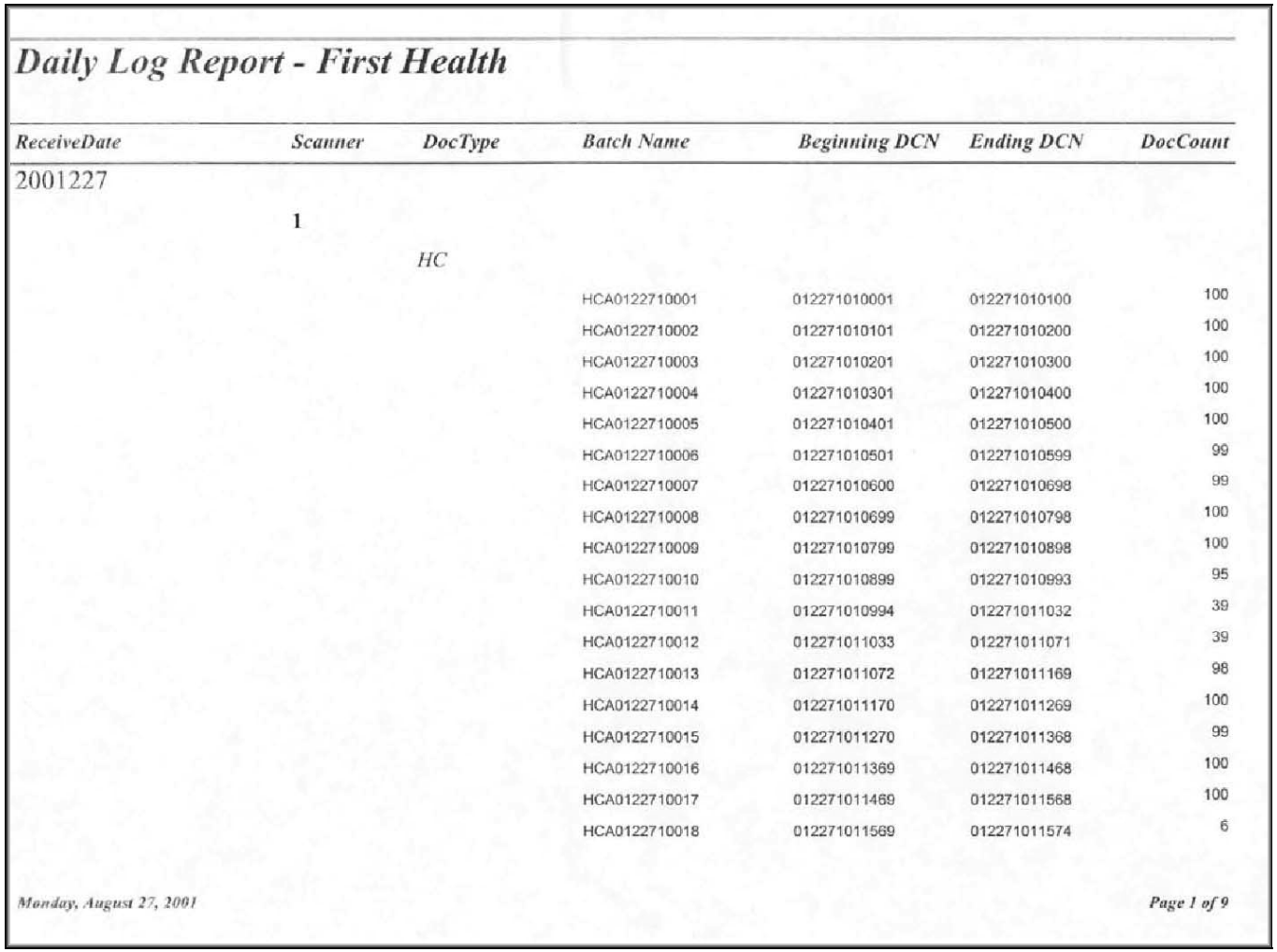
1. Child Care; 2. Food Stamps; 3. Housing; 4. Nutrition Counseling; 5. Parenting Education; 6. Home Health Services; 7. Employment; 8. Counseling; 9. School Enrollment; 10. Job Training; 11. Transportation

_____ Coordinator's Signature _____ Date

DMAS – 54 Rev. 3/03

Sample VDMAS Infant Outcome Report

Appendix B Daily Log Report

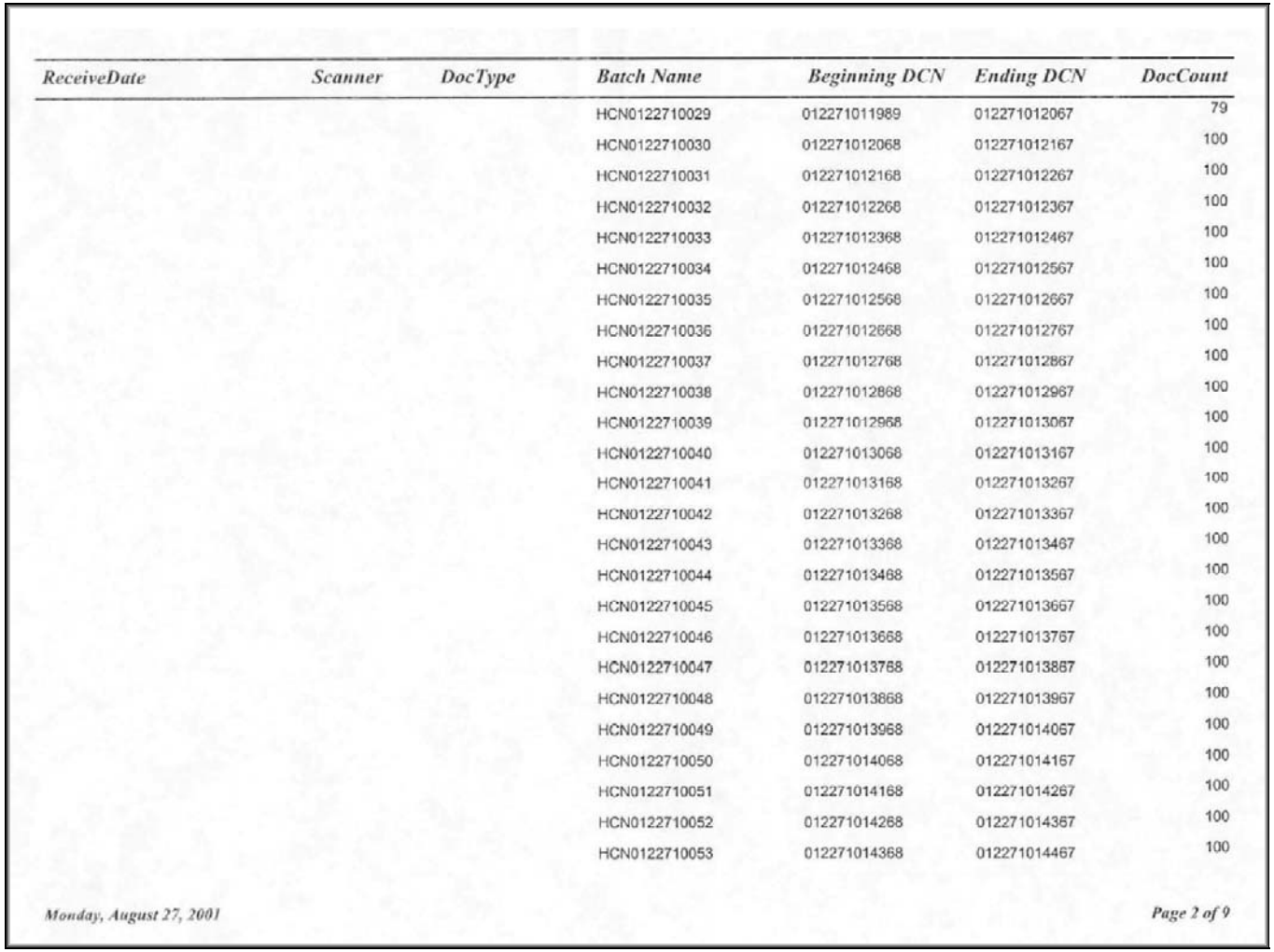


Daily Log Report - First Health

ReceiveDate	Scanner	DocType	Batch Name	Beginning DCN	Ending DCN	DocCount
2001227						
	1					
		HC				
			HCA0122710001	012271010001	012271010100	100
			HCA0122710002	012271010101	012271010200	100
			HCA0122710003	012271010201	012271010300	100
			HCA0122710004	012271010301	012271010400	100
			HCA0122710005	012271010401	012271010500	100
			HCA0122710006	012271010501	012271010599	99
			HCA0122710007	012271010600	012271010698	99
			HCA0122710008	012271010699	012271010798	100
			HCA0122710009	012271010799	012271010898	100
			HCA0122710010	012271010899	012271010993	95
			HCA0122710011	012271010994	012271011032	39
			HCA0122710012	012271011033	012271011071	39
			HCA0122710013	012271011072	012271011169	98
			HCA0122710014	012271011170	012271011269	100
			HCA0122710015	012271011270	012271011368	99
			HCA0122710016	012271011369	012271011468	100
			HCA0122710017	012271011469	012271011568	100
			HCA0122710018	012271011569	012271011574	6

Monday, August 27, 2001 *Page 1 of 9*

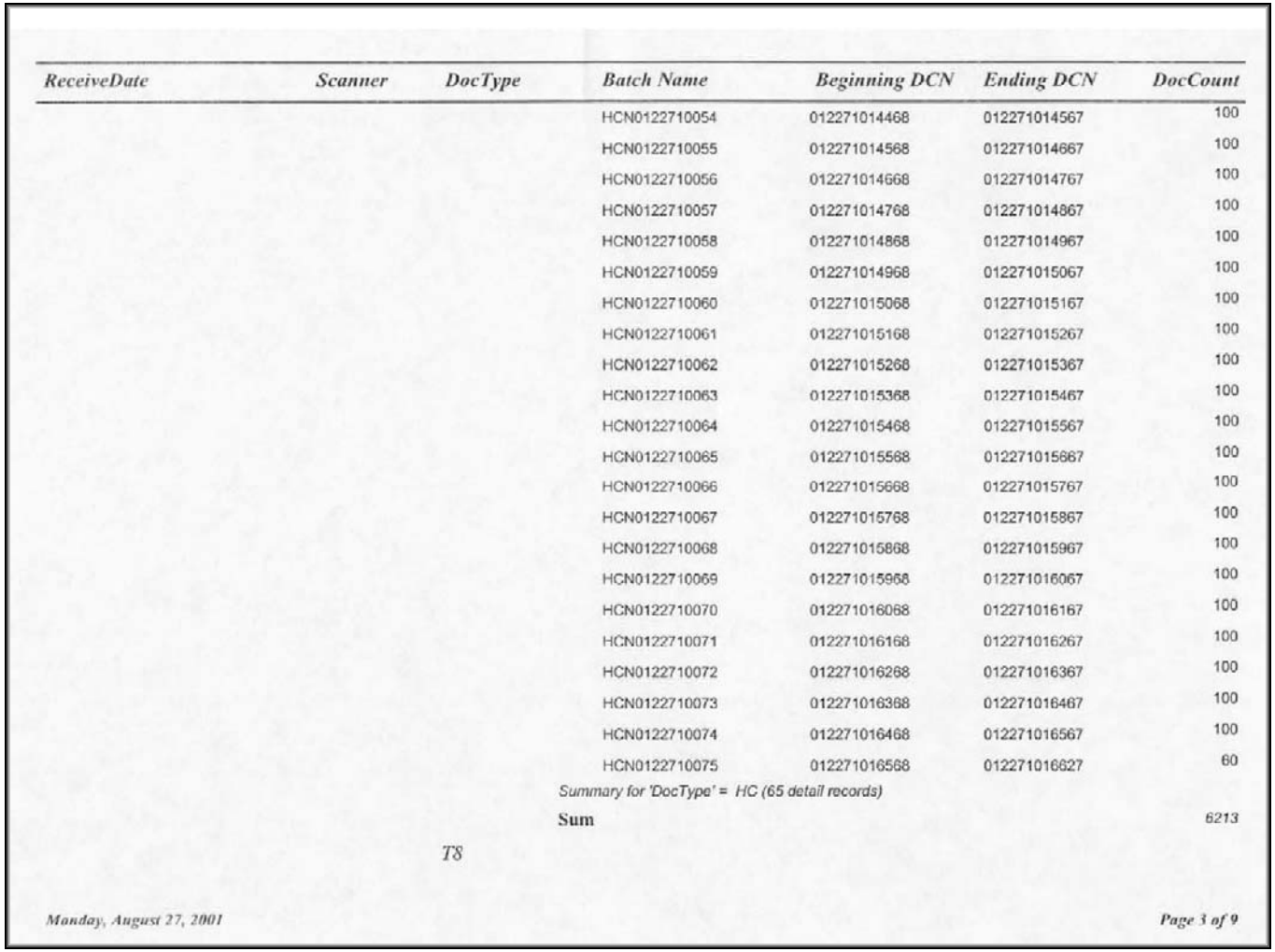
Daily Log Report



ReceiveDate	Scanner	DocType	Batch Name	Beginning DCN	Ending DCN	DocCount
			HCN0122710029	012271011989	012271012067	79
			HCN0122710030	012271012068	012271012167	100
			HCN0122710031	012271012168	012271012267	100
			HCN0122710032	012271012268	012271012367	100
			HCN0122710033	012271012368	012271012467	100
			HCN0122710034	012271012468	012271012567	100
			HCN0122710035	012271012568	012271012667	100
			HCN0122710036	012271012668	012271012767	100
			HCN0122710037	012271012768	012271012867	100
			HCN0122710038	012271012868	012271012967	100
			HCN0122710039	012271012968	012271013067	100
			HCN0122710040	012271013068	012271013167	100
			HCN0122710041	012271013168	012271013267	100
			HCN0122710042	012271013268	012271013367	100
			HCN0122710043	012271013368	012271013467	100
			HCN0122710044	012271013468	012271013567	100
			HCN0122710045	012271013568	012271013667	100
			HCN0122710046	012271013668	012271013767	100
			HCN0122710047	012271013768	012271013867	100
			HCN0122710048	012271013868	012271013967	100
			HCN0122710049	012271013968	012271014067	100
			HCN0122710050	012271014068	012271014167	100
			HCN0122710051	012271014168	012271014267	100
			HCN0122710052	012271014268	012271014367	100
			HCN0122710053	012271014368	012271014467	100

Monday, August 27, 2001 *Page 2 of 9*

Daily Log Report

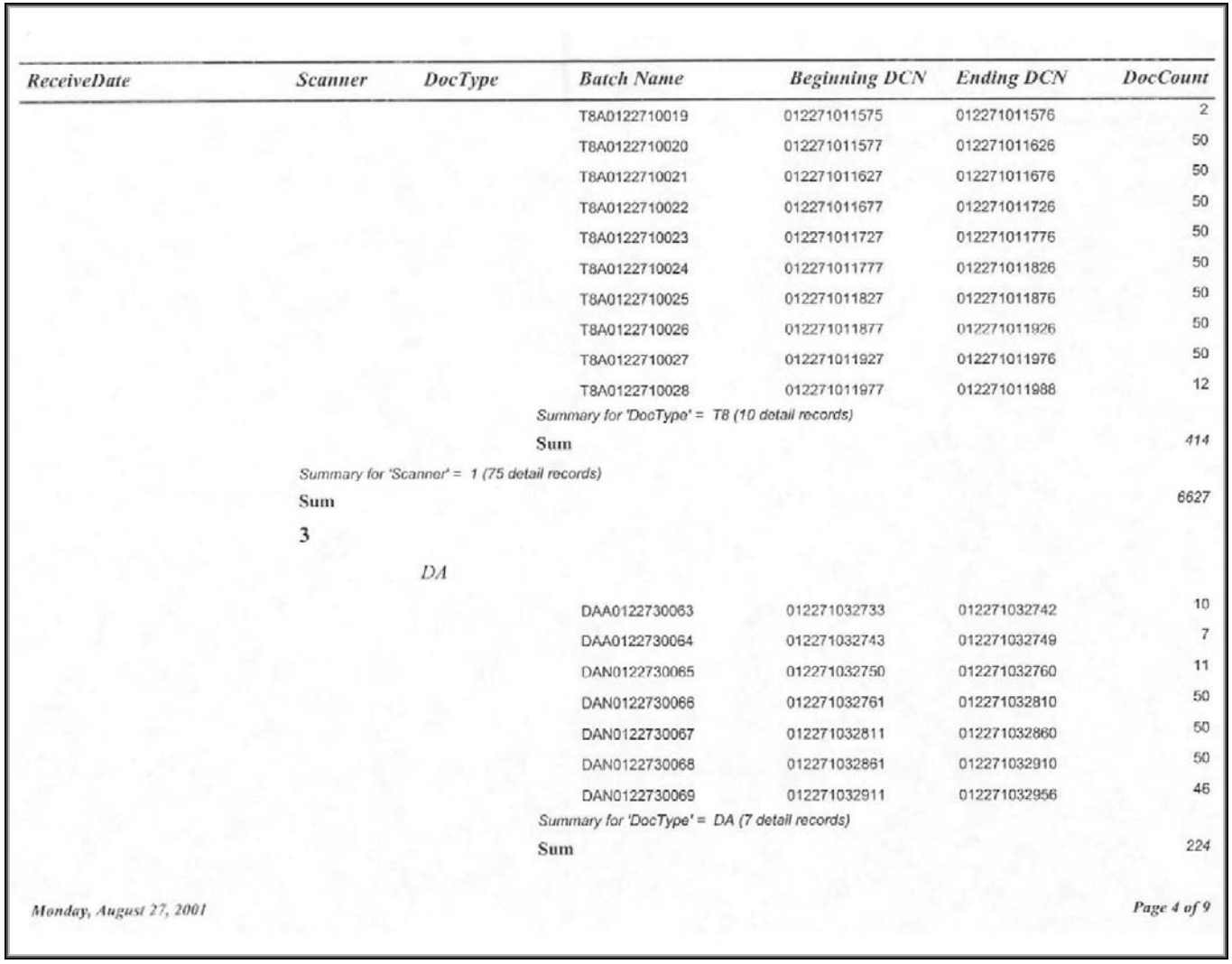


ReceiveDate	Scanner	DocType	Batch Name	Beginning DCN	Ending DCN	DocCount
			HCN0122710054	012271014468	012271014567	100
			HCN0122710055	012271014568	012271014667	100
			HCN0122710056	012271014668	012271014767	100
			HCN0122710057	012271014768	012271014867	100
			HCN0122710058	012271014868	012271014967	100
			HCN0122710059	012271014968	012271015067	100
			HCN0122710060	012271015068	012271015167	100
			HCN0122710061	012271015168	012271015267	100
			HCN0122710062	012271015268	012271015367	100
			HCN0122710063	012271015368	012271015467	100
			HCN0122710064	012271015468	012271015567	100
			HCN0122710065	012271015568	012271015667	100
			HCN0122710066	012271015668	012271015767	100
			HCN0122710067	012271015768	012271015867	100
			HCN0122710068	012271015868	012271015967	100
			HCN0122710069	012271015968	012271016067	100
			HCN0122710070	012271016068	012271016167	100
			HCN0122710071	012271016168	012271016267	100
			HCN0122710072	012271016268	012271016367	100
			HCN0122710073	012271016368	012271016467	100
			HCN0122710074	012271016468	012271016567	100
			HCN0122710075	012271016568	012271016627	60
			Summary for 'DocType' = HC (65 detail records)			
			Sum			6213

T8

Monday, August 27, 2001 *Page 3 of 9*

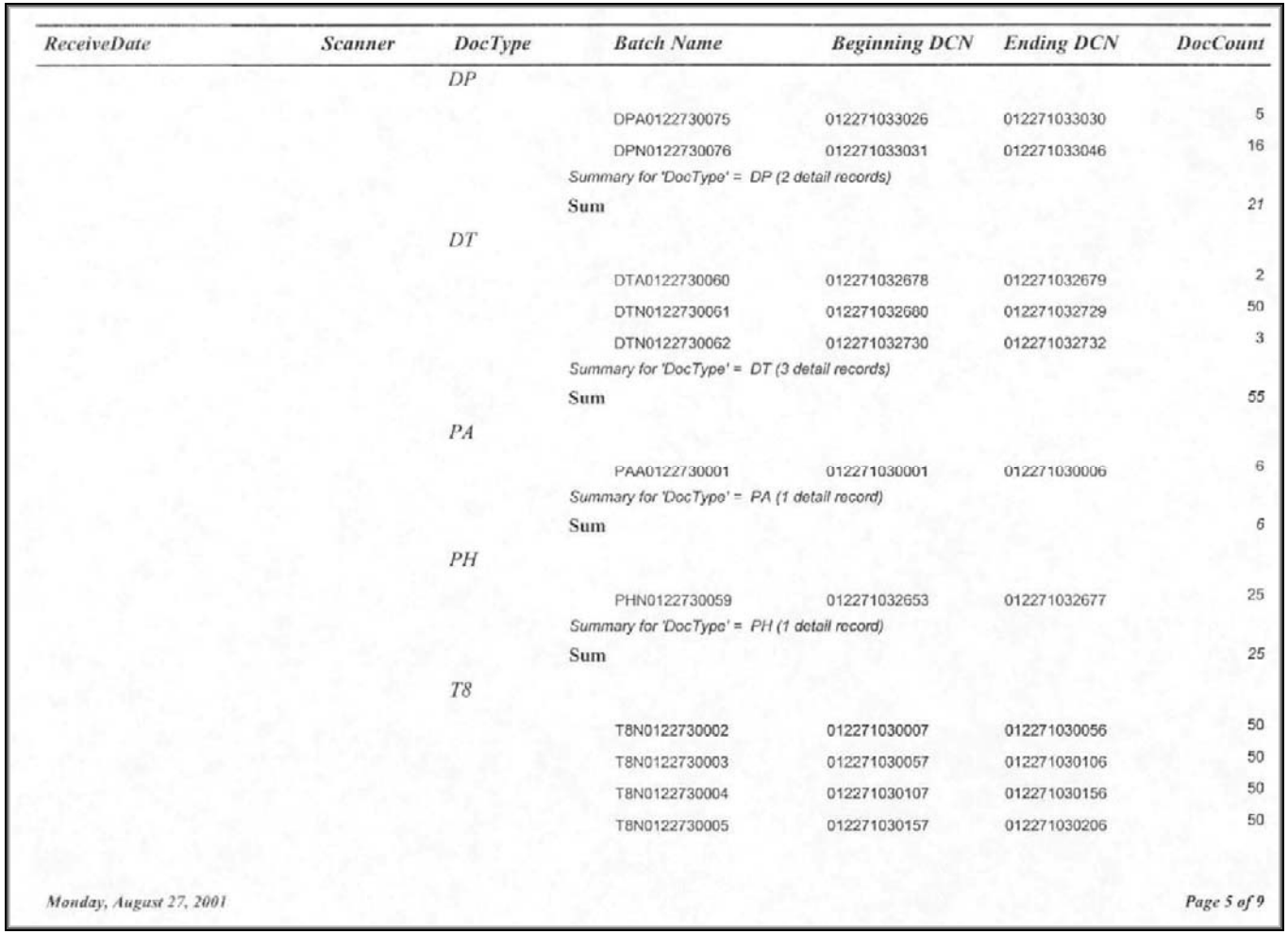
Daily Log Report



ReceiveDate	Scanner	DocType	Batch Name	Beginning DCN	Ending DCN	DocCount
			T8A0122710019	012271011575	012271011576	2
			T8A0122710020	012271011577	012271011626	50
			T8A0122710021	012271011627	012271011676	50
			T8A0122710022	012271011677	012271011726	50
			T8A0122710023	012271011727	012271011776	50
			T8A0122710024	012271011777	012271011826	50
			T8A0122710025	012271011827	012271011876	50
			T8A0122710026	012271011877	012271011926	50
			T8A0122710027	012271011927	012271011976	50
			T8A0122710028	012271011977	012271011988	12
		Summary for 'DocType' = T8 (10 detail records)				
		Sum				*414*
	Summary for 'Scanner' = 1 (75 detail records)					
	Sum					*6627*
	3					
		DA				
			DAA0122730063	012271032733	012271032742	10
			DAA0122730064	012271032743	012271032749	7
			DAN0122730065	012271032750	012271032760	11
			DAN0122730066	012271032761	012271032810	50
			DAN0122730067	012271032811	012271032860	50
			DAN0122730068	012271032861	012271032910	50
			DAN0122730069	012271032911	012271032956	46
		Summary for 'DocType' = DA (7 detail records)				
		Sum				*224*

Monday, August 27, 2001 *Page 4 of 9*

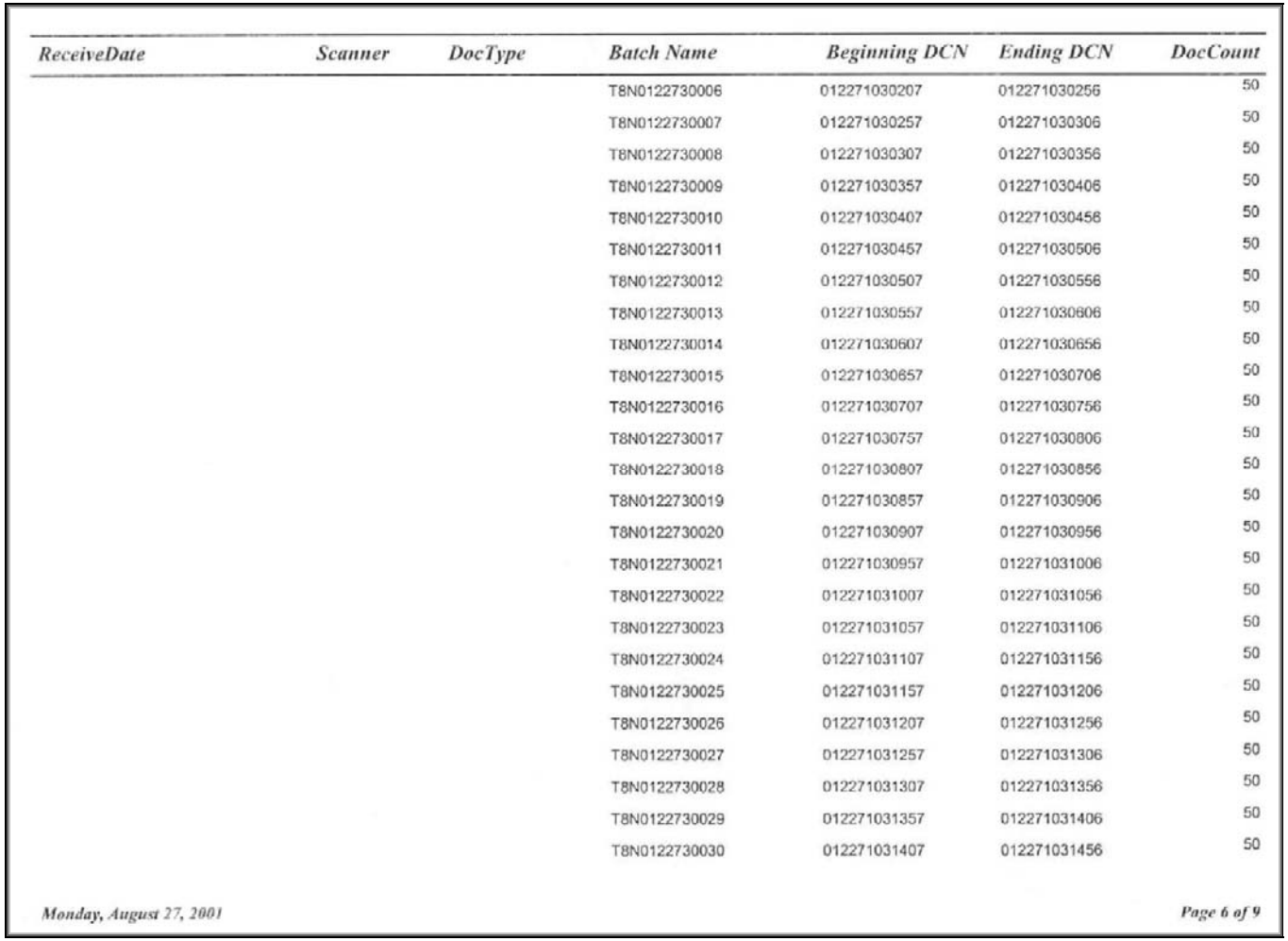
Daily Log Report



ReceiveDate	Scanner	DocType	Batch Name	Beginning DCN	Ending DCN	DocCount
		DP				
			DPA0122730075	012271033026	012271033030	5
			DPN0122730076	012271033031	012271033046	16
			Summary for 'DocType' = DP (2 detail records)			
			Sum			21
		DT				
			DTA0122730060	012271032678	012271032679	2
			DTN0122730061	012271032680	012271032729	50
			DTN0122730062	012271032730	012271032732	3
			Summary for 'DocType' = DT (3 detail records)			
			Sum			55
		PA				
			PAA0122730001	012271030001	012271030006	6
			Summary for 'DocType' = PA (1 detail record)			
			Sum			6
		PH				
			PHN0122730059	012271032653	012271032677	25
			Summary for 'DocType' = PH (1 detail record)			
			Sum			25
		T8				
			T8N0122730002	012271030007	012271030056	50
			T8N0122730003	012271030057	012271030106	50
			T8N0122730004	012271030107	012271030156	50
			T8N0122730005	012271030157	012271030206	50

Monday, August 27, 2001 Page 5 of 9

Daily Log Report



ReceiveDate	Scanner	DocType	Batch Name	Beginning DCN	Ending DCN	DocCount
			T8N0122730006	012271030207	012271030256	50
			T8N0122730007	012271030257	012271030306	50
			T8N0122730008	012271030307	012271030356	50
			T8N0122730009	012271030357	012271030406	50
			T8N0122730010	012271030407	012271030456	50
			T8N0122730011	012271030457	012271030506	50
			T8N0122730012	012271030507	012271030556	50
			T8N0122730013	012271030557	012271030606	50
			T8N0122730014	012271030607	012271030656	50
			T8N0122730015	012271030657	012271030706	50
			T8N0122730016	012271030707	012271030756	50
			T8N0122730017	012271030757	012271030806	50
			T8N0122730018	012271030807	012271030856	50
			T8N0122730019	012271030857	012271030906	50
			T8N0122730020	012271030907	012271030956	50
			T8N0122730021	012271030957	012271031006	50
			T8N0122730022	012271031007	012271031056	50
			T8N0122730023	012271031057	012271031106	50
			T8N0122730024	012271031107	012271031156	50
			T8N0122730025	012271031157	012271031206	50
			T8N0122730026	012271031207	012271031256	50
			T8N0122730027	012271031257	012271031306	50
			T8N0122730028	012271031307	012271031356	50
			T8N0122730029	012271031357	012271031406	50
			T8N0122730030	012271031407	012271031456	50

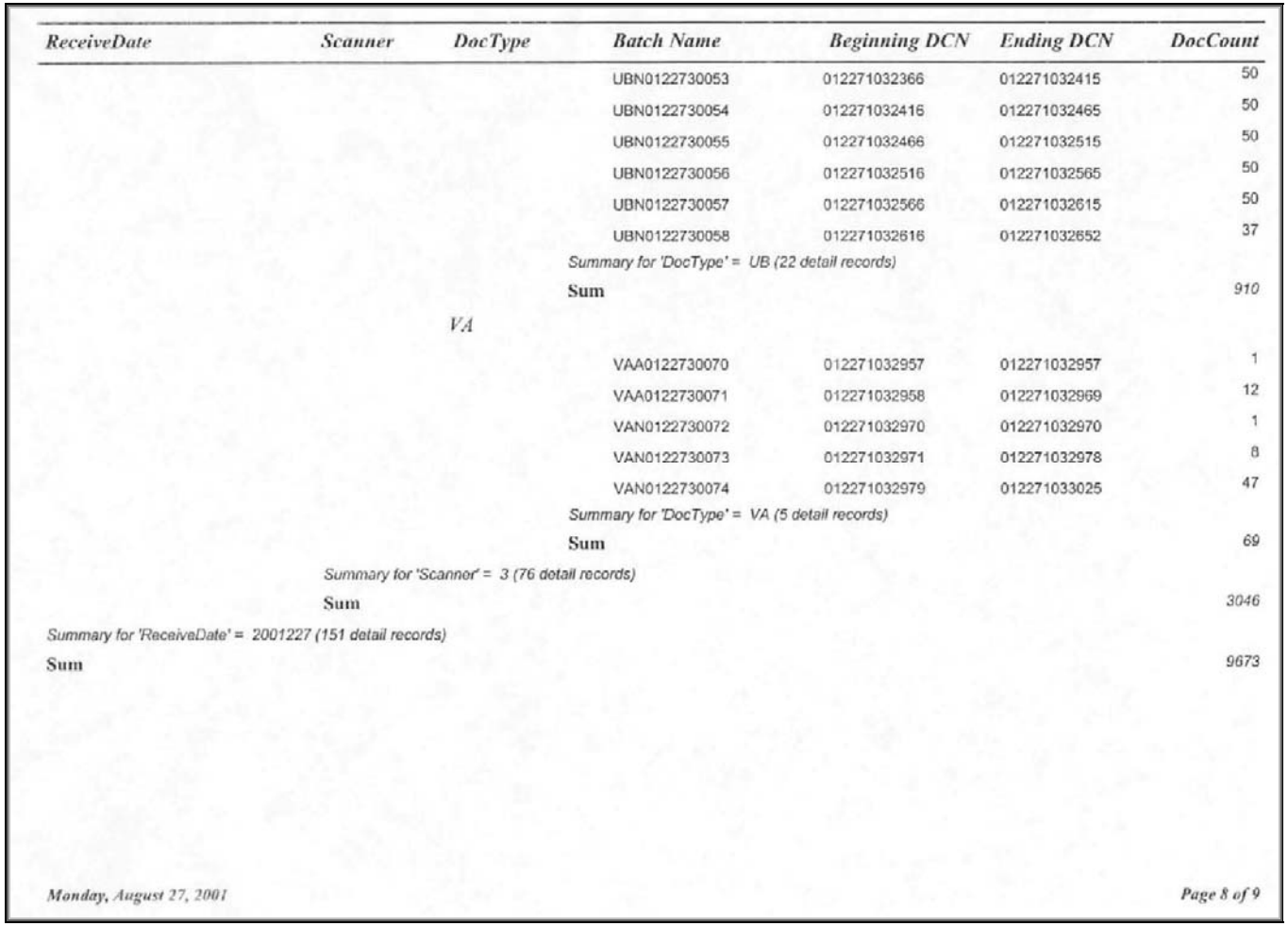
Monday, August 27, 2001 *Page 6 of 9*

Daily Control Log

ReceiveDate	Scanner	DocType	Batch Name	Beginning DCN	Ending DCN	DocCount
			T8N0122730031	012271031457	012271031506	50
			T8N0122730032	012271031507	012271031556	50
			T8N0122730033	012271031557	012271031606	50
			T8N0122730034	012271031607	012271031656	50
			T8N0122730035	012271031657	012271031706	50
			T8N0122730036	012271031707	012271031742	36
			Summary for 'DocType' = T8 (35 detail records)			
			Sum			*1736*
		UB				
			UBA0122730037	012271031743	012271031743	1
			UBA0122730038	012271031744	012271031755	12
			UBA0122730039	012271031756	012271031805	50
			UBA0122730040	012271031806	012271031853	48
			UBA0122730041	012271031854	012271031903	50
			UBA0122730042	012271031904	012271031911	8
			UBN0122730043	012271031912	012271031915	4
			UBN0122730044	012271031916	012271031965	50
			UBN0122730045	012271031966	012271032015	50
			UBN0122730046	012271032016	012271032065	50
			UBN0122730047	012271032066	012271032115	50
			UBN0122730048	012271032116	012271032165	50
			UBN0122730049	012271032166	012271032215	50
			UBN0122730050	012271032216	012271032265	50
			UBN0122730051	012271032266	012271032315	50
			UBN0122730052	012271032316	012271032365	50

Monday, August 27, 2001 *Page 7 of 9*

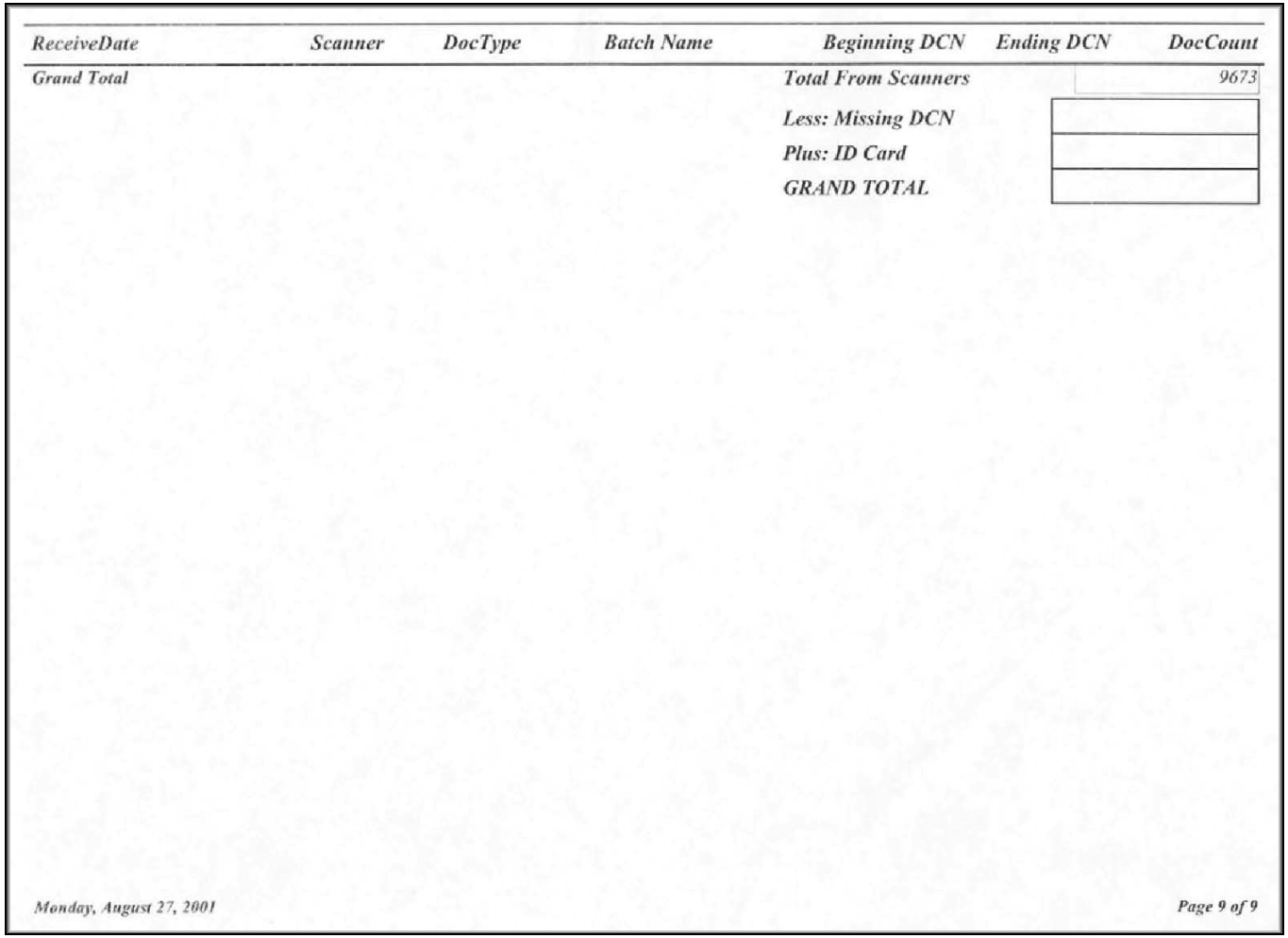
Daily Log Report



ReceiveDate	Scanner	DocType	Batch Name	Beginning DCN	Ending DCN	DocCount
			UBN0122730053	012271032366	012271032415	50
			UBN0122730054	012271032416	012271032465	50
			UBN0122730055	012271032466	012271032515	50
			UBN0122730056	012271032516	012271032565	50
			UBN0122730057	012271032566	012271032615	50
			UBN0122730058	012271032616	012271032652	37
			Summary for 'DocType' = UB (22 detail records)			
			Sum			*910*
		VA				
			VAA0122730070	012271032957	012271032957	1
			VAA0122730071	012271032958	012271032969	12
			VAN0122730072	012271032970	012271032970	1
			VAN0122730073	012271032971	012271032978	8
			VAN0122730074	012271032979	012271033025	47
			Summary for 'DocType' = VA (5 detail records)			
			Sum			69
	Summary for 'Scanner' = 3 (76 detail records)					
	Sum					*3046*
Summary for 'ReceiveDate' = 2001227 (151 detail records)						
Sum						*9673*

Monday, August 27, 2001 *Page 8 of 9*

Daily Log Report



ReceiveDate	Scanner	DocType	Batch Name	Beginning DCN	Ending DCN	DocCount
Grand Total				Total From Scanners		9673
				Less: Missing DCN		
				Plus: ID Card		
				GRAND TOTAL		

Monday, August 27, 2001 Page 9 of 9

Daily Log Report

Appendix C Data Capture Instructions

The instructions listed below are utilized in capturing data to allow processing of claims data for the Commonwealth of Virginia.

Pharmacy		
Data Element Name	**Block #**	**Comments**
ICN-Number	ICN	Automatically populated. Not a keyed field.
Billing-Provider-No	1	Enter out of the field when blank or nonnumeric characters such as alpha or special characters are coded. Data not falling within the validity check will require rekeying. When too long or too short, key as much as you can.
Patient-Name	2	Key the first 5 characters. Ignore punctuation.
Enrollee-ID	3	Alpha characters are invalid and should not be keyed. If too long or too short, key as much as you can ignoring alpha characters. Enter out of the field when blank. Data not falling within the validity check will require re-keying.
Enrollee-DOB	5	Key in MMDDYY format.
Level-Of-Service	6	Data not falling within the validity check will require

Pharmacy		
Data Element Name	**Block #**	**Comments**
		re-keying.
Days-Supply	7	Only numeric values are allowed.
Refill-Code	8	Only numeric values are allowed.
DAW	9	Valid entries are 0-9, and blank.
Patient-Location	10	Data not falling within the validity check will require re-keying.
Adjustment Reason	11	Only numeric values are allowed.
Former ICN-No	12	Alpha and numeric characters are allowed.Ignore special characters.
Prescription-Number	13	Only numeric values are allowed. If too long or too short, key as much as you can.
Date-Dispensed	14	Key in MMDDYY format.
NDC	15	Only numeric values are allowed.
Metric-Quantity Quantity	16a	Key everything in front of the preprinted bar.
Metric-Quantity Decimal	16b	Key everything behind the preprinted bar.
Unit Dose IND	17	Data not falling within the validity check will require re-keying.
Copay-Exempt	18	Data not falling within the validity check will require rekeying.
PA-Number	19	Only numeric values are allowed.
Prescribing-Physician	20	Enter out of the field when blank or nonnumeric characters are coded. Data not falling within the validity check will require re-keying.
Diagnosis-Code	21	Ignore decimal points. Data not falling within the validity checks will require rekeying.
Billed-Charge	22	Key numeric values as coded.
COB-Indicator	23	Data not falling within the validity checks will require re-keying.
Third-Party-Payment	24	Key numeric values as coded.
Disp-Stat-Cval	25	Data not falling within the validity check will require re-keying.
Qty Intended To Be Dispensed	26	Key numeric values as coded.
Intended Days Supply	27	Key numeric values as coded.

Pharmacy		
Data Element Name	**Block #**	**Comments**
Associated Rx Number	28	Key numeric values as coded.
Associated Date Dispensed	29	Key numeric values as coded.
Attachment/Remarks Indicator	30	1= Remarks 2= No Remarks

Pharmacy Compound		
Data Element Name	**Block #**	**Comments**
ICN-Number	DCN	Automatically populated. Not a keying field.
Adjustment-Reason	01	Only numeric values are allowed.
Former-ICN-No	02	Alpha and numeric characters are allowed. Ignore special characters.
Billing-Provider-No	04	Enter out of the field when blank or nonnumeric characters such as alpha or special characters are coded. Data not falling within the validity check will require re-keying. When too long or too short, key as much as you can.
Level-Of-Service	05	Only numeric values are allowed. Data not falling within the validity check will require re-keying.
Diagnosis-Code	06	Ignore decimal points. Data not falling within the validity check will require re keying.
Copay-Exempt	07	Data not falling within the validity check will require re-keying
PA-Number	08	Alpha and numeric characters are allowed.
Enrollee-ID	09	Alpha characters are invalid and should not be keyed. If too long or too short, key as much as you can ignoring alpha characters. Enter out of the field when blank. Data not falling within the validity check will require re-keying.
Patient-Name	10	Key the first 5 characters. Ignore punctuation.
Enrollee-DOB	12	Key in MMDDYY format.
Prescribing-Physician (Rx #)	13	Enter out of the field when blank. Ignore alpha characters. Data not falling within the validity check will require re-keying. When too long or too short, key as much as you can.
Prescription-Number	14	Only numeric values are allowed.

Pharmacy Compound		
Data Element Name	**Block #**	**Comments**
Date-Dispensed	15	Key in MMDDYY format.
Days-Supply	16	Only numeric values are allowed.
Refill-Code	17	Only numeric values are allowed.
Patient-Location	18	Only numeric values are allowed.
NDS	19	Only numeric values are allowed
DAW	20	Valid entries are 0-9 and blank.
Metric-Quantity	22a	Only numeric values are allowed.
Metric-Decimal-Quantity	22b	Only numeric values are allowed
COB-Indicator	23	Only numeric values are allowed. Data not falling within the validity check will require re- keying
Third-Party-Payment	24	Key numeric values as coded.
Billed-Charge	25	Key numeric values as coded.
Attachment/Remark-Indicator	26	1=Remarks, 2=No Remarks
Notes:		

Title 18		
Data Element Name	**Block #**	**Comments**
ICN-Number	ICN	Automatically Populated - Not a keyed field .
Billing-Provider Number	01	Enter out of the field when nonnumeric characters such as alpha or special characters are coded. Data not falling within the validity checks of 7, 9 or 10 digits will require rekeying. Leading zeroes must be keyed when coded.
Patient-Name	02	Key in the first 5 characters. Ignore all punctuation.
Recipient ID Number	4	*Alpha characters are invalid and should not be keyed. If too short or too long, key as much as you can ignoring alpha characters.
Patient-Acct-Number	5	Ignore punctuation.
Rendering Provider Number	6	Enter out of the field when nonnumeric characters such as alpha or special characters are coded. Data not falling within the validity checks of 7, 9 or 10 digits will require rekeying. Leading zeroes must be keyed when coded.

<table>
<tr><th colspan="3">Title 18</th></tr>
<tr><th>Data Element Name</th><th>Block #</th><th>Comments</th></tr>
<tr><td>Special (TDO/ECO) Processing Indicator</td><td>Space above Blocks (13) and (14)</td><td>This is an auto skip field that is only used for special processing.</td></tr>
<tr><td>COB-Code</td><td>7</td><td>Key the numeral that is printed to the right of the marked checkbox.<table><tr><th>Key</th><th>For</th></tr><tr><td>2</td><td>No Other Coverage</td></tr><tr><td>3</td><td>Billed and Paid</td></tr><tr><td>5</td><td>Billed No Coverage</td></tr></table></td></tr>
<tr><td>Type Of Coverage - Medicare</td><td>8</td><td>If the Type of Coverage block is checked key a B. Enter out of the field when blank.</td></tr>
<tr><td>Medicare-Diagnosis - CD</td><td>9</td><td>If more than one code is coded, key the first code. If too long, key as much as you can. Ignore punctuation.</td></tr>
<tr><td>Place-Of-Treatment</td><td>10</td><td>Data not falling within the validity checks will require rekeying.</td></tr>
<tr><td>Indicator: Accident, Emergency, Other Accident</td><td>11</td><td>All 3 boxes in Form Locator 11 will be keyed as one field. The first checked box will take precedence, i.e., if the ACC box is checked and so is the EMER box, only the ACC check will count. Enter out of the field when blank.</td></tr>
<tr><td>Type-Of-Service</td><td>12</td><td>Data not falling within the validity checks will require rekeying. Alpha and numeric characters are valid.</td></tr>
<tr><td>Princ-Proc-Code</td><td>13</td><td>Key as coded. If 7 digits are coded key the first 5 as the procedure code and the next 2 as the modifier. Data not falling within the validity checks will require rekeying.</td></tr>
<tr><td>Proc-Modifier</td><td>13A</td><td>The modifier should be coded behind the preprinted line of Block 13. Data not falling within the validity checks will require rekeying.</td></tr>
<tr><td>UVS</td><td>14</td><td>Valid entries are 00000 thru 99999. Any entry over 999 will require rekeying.</td></tr>
<tr><td>Servc-From-Date</td><td>16.1</td><td>This date must be entered in the MMDDYY (month, day, and year) format.The month and day portion of the date will be checked for valid entries.</td></tr>
</table>

Title 18		
Data Element Name	**Block #**	**Comments**
Servc-Thru-Date	16.2	This date must be entered in the MMDDYY (month, day, and year) format. The month and day portion of the date will be checked for valid entries.
Charges To Medicare	17	Only numeric digits allowed.
Allowed By Medicare	18	Only numeric digits are allowed. Out of balance amounts will be repositioned for rekeying.
Paid By Medicare	19	Only numeric digits are allowed. Out of balance amounts will be repositioned for rekeying.
Deductible	20	Only numeric digits are allowed. Out of balance amounts will be repositioned for rekeying.
Coinsurance	21	Only numeric digits are allowed. Out of balance amounts will be repositioned for rekeying.
TPL-Amount	22	This field is automatically skipped. If data is coded, entry operator can either back up to key the coded data or turn the Auto Skip off before getting to this field.
Patient-Pay-Amount	23	This field is automatically skipped. If data is coded, entry operator can either back up to key the coded data or turn the Auto Skip off before getting to this field. Key numeric values as coded.
NDC	24	Ignore special characters such as dashes (-).
Attachment/Remark Indicator	25	1 = Remarks 2 = No Remarks
Notes:		

Title 18 Adjustment/Void		
Data Element Name	**Block #**	**Comments**
ICN-Number	ICN	Automatically Populated - Not a keyed field.
Adjustment/Void	1	Key the code beside the box that is checked. If the **094** code is keyed, the **Void** screen is displayed which only requires the keying of block #'s with an (*). If the **092** code is keyed, the **Adjustment** screen is displayed for the keying of the entire form.
Billing-Provider-Number	2	Enter out of the field when nonnumeric characters such as alpha or special characters are coded. Data

<table>
<tr><th colspan="3">Title 18 Adjustment/Void</th></tr>
<tr><th>Data Element Name</th><th>Block #</th><th>Comments</th></tr>
<tr><td></td><td></td><td>not falling within the validity checks of 7, 9 or 10 digits will require rekeying. Leading zeroes must be keyed when coded.</td></tr>
<tr><td>ICN/Reference Number</td><td>A</td><td>Alpha and numeric characters are allowed. Ignore special characters.</td></tr>
<tr><td>Reason</td><td>B</td><td>Key numeric values as coded.</td></tr>
<tr><td>Input Code</td><td>C</td><td>Key numeric values as coded.</td></tr>
<tr><td>Patient-Name</td><td>3</td><td>Key in the first 5 characters. Ignore all punctuation.</td></tr>
<tr><td>Recipient ID</td><td>4</td><td>*Alpha characters are invalid and should not be keyed. If too short or too long, key as much as you can ignoring alpha characters.</td></tr>
<tr><td>Patient-Acct-Number</td><td>5</td><td>Ignore Punctuation.</td></tr>
<tr><td>Rendering Provider Number</td><td>6</td><td>Enter out of the field when nonnumeric characters such as alpha or special characters are coded. Data not falling within the validity checks of 7, 9 or 10 digits will require rekeying. Leading zeroes must be keyed when coded.</td></tr>
<tr><td>COB-Code</td><td>7</td><td>Key the numeral that is printed to the right of the marked checkbox.<table><tr><th>Key</th><th>For</th></tr><tr><td>2</td><td>No Other Coverage</td></tr><tr><td>3</td><td>Billed and Paid</td></tr><tr><td>5</td><td>Billed No Coverage</td></tr></table></td></tr>
<tr><td>Type Of Coverage - Medicare</td><td>8</td><td>If the Type of Coverage block is checked key a B. Enter out of the field when blank.</td></tr>
<tr><td>Medicare-Diagnosis-CD</td><td>9</td><td>If more than one code is coded, key the first code. If too long, key as much as you can. Ignore punctuation. Alpha and numeric characters are allowed.</td></tr>
<tr><td>Place-Of-Treatment</td><td>10</td><td>Data not falling within the validity checks will require rekeying. Only numeric values are allowed.</td></tr>
<tr><td>Indicator: Accident , Emergency, Other Accident</td><td>11</td><td>All 3 boxes in Form Locator 11 will be keyed as one field. The first checked box will take precedence, i.e., if the ACC box is checked and so is the EMER box, only the ACC check will count. Enter out of the</td></tr>
</table>

Title 18 Adjustment/Void		
Data Element Name	**Block #**	**Comments**
		field when blank.
Type-Of-Service	12	Alpha and numeric characters are valid.
Princ-Proc-Code	13	Key as coded. If seven characters are coded key the first five as the procedure code and the next two as the modifier. Data not falling within the validity checks will require rekeying. Alpha and numeric characters are allowed.
Proc-Modifier	13A	The modifier should be the last two characters of a seven-character Procedure Code. When the Procedure Code contains five or less, enter out of the **Modifier** field. Data not falling within the validity checks will require rekeying. Alpha and numeric characters are allowed.
UVS	14	Valid entries are 00000 thru 99999. Any entry over 999 will require rekeying.
Servc-From-Date	16.1	This date must be entered in the MMDDYY (month, day, and year) format. The month and day portion of the date will be checked for valid entries.
Servc-Thru-Date	16.2	This date must be entered in the MMDDYY (month, day, and year) format. The month and day portion of the date will be checked for valid entries.
Charges To Medicare	17	Key numeric values as coded.
Allowed By Medicare	18	Key numeric values as coded. Out of balance amounts will be repositioned for rekeying.
Paid By Medicare	19	Key numeric values as coded. Out of balance amounts will be repositioned for rekeying.
Deductible	20	Key numeric values as coded. Out of balance amounts will be repositioned for rekeying.
Coinsurance	21	Key numeric values as coded. Only numeric digits are allowed. Out of balance amounts will be repositioned for rekeying.
TPL-Amount	22	This field is automatically skipped. If data is coded, entry operator can either back up to key the coded data or turn the Auto Skip (F2) off before getting to this field. Key numeric values as coded.
Patient-Pay-Amount	23	This field is automatically skipped. If data is coded,

Title 18 Adjustment/Void		
Data Element Name	**Block #**	**Comments**
		entry operator can either back up to key the coded data or turn the Auto Skip (F2) off before getting to this field. Key numeric values as coded.
NDC	24	Ignore special characters such as dashes (-).
Special (TDO/ECO) Processing Indicator	Beside Block (24)	This is an auto skip field that is only used for special processing.

CMS-1500		
Data Element Name	**Block #**	**Comments**
ICN-Number	DCN	Automatically populated. Not a keying field.
Enrollee-ID	1a	*Alpha characters are invalid and should not be keyed. If too short or too long, key as much as you can ignoring alpha characters.
Special Process Indicator (TDO/EDO)	9	This is a auto skip field that is only used for special TDO/ECO processing.
Pat-Cond-Empl	10a	Key a *1* if the **Yes** box is checked and a *2* if the **No** box is checked.
Pat-Cond-Auto	10b	Key *1* if the **Yes** box is checked and a *2* if the **No** box is checked.
Pat-Cond-Other	10c	Key *1* if the **Yes** box is checked and a *2* if the **No** box is checked.
Insured-Plan-Name	11c	Ignore Punctuation; Key only when **HMO Copay** is coded.
Insured-COB-IND	11d	Key *1* if the **Yes** box is checked and a *2* if the **No** box is checked. If both boxes are checked, key a *1*.
Date-Of-Illness	14	This date must be entered in the MMDDYY (month, day, and year) format.
Referring-Physician Qualifier	17a	Key only when a qualifier of **1D** is coded.
Referring-Phys-ID	17a.1	Key this field only if the **Referring-Physician Qualifie**r field (17a) is coded with a qualifier of **1D**. If not, enter out of the field. Also enter out of the field when nonnumeric characters such as alpha or special characters are coded. Data not falling within the validity check of 7, 9 or 10 digits will require rekeying.

CMS-1500		
Data Element Name	**Block #**	**Comments**
NPI Referring Physician	17b	Enter out of the field when nonnumeric characters such as alpha or special characters are coded. Data not falling within the validity check of 7, 9 or 10 digits will require rekeying.
CLIA-Number	19	Key as much as you can of this alpha/numeric field, ignoring descriptive words.
Principal-Diag-Code	21.1	Do not include decimal points in the key entry. Alpha and numeric characters are allowed. Data not falling within the validity check will require rekeying.
Second-Diag-Code	21.2	Do not include decimal points in the key entry. Alpha and numeric characters are allowed. Data not falling within the validity check will require rekeying.
Third-Diag-Code	21.3	Do not include decimal points in the key entry. Alpha and numeric characters are allowed. Data not falling within the validity check will require rekeying.
Fourth-Diag-Code	21.4	Do not include decimal points in the key entry. Alpha and numeric characters are allowed. Data not falling within the validity check will require rekeying.
Adjustment-Reason	22.1	Only numeric values are allowed.
Former-ICN-No	22 .2	Alpha and numeric characters are allowed. Ignore special characters.
PA-Number	23	Alpha characters are invalid. If too long, key as much as you can.
Supplemental -Data	24a-24e (shaded)	This field is the (clear/shaded) space above each line. It is a free form field which means all data should be keyed with no spaces. Special characters such as decimals are valid and should be keyed. Providers are instructed to code data such as TPL27.08 and/or N400026064871
Srvc-From-Date	24a.1	Date must be entered in MMDDYY (month, day, and year) format. Month and day entries will require rekeying when invalid. Year will require rekeying if older than two years.

CMS-1500		
Data Element Name	**Block #**	**Comments**
Srvc-Thru-Date	24a.2	Date must be entered in MMDDYY (month, day, and year) format. Month and day entries will require rekeying when invalid. Year will require rekeying if older than two years.
Prof-Place-Of-Srvc	24b	Alpha and numeric characters are allowed. Data not falling within the validity check will require rekeying.
EMG	24c	Key a *1* only if 1 or Y is coded in this field. **Note:** An X is not valid and should not be keyed.
Princ-Proc-Code	24d.1	Alpha and numeric characters are allowed. Data not falling within the validity check will require rekeying.
Prof-Proc-Modifier	24d.2	Screen displays one eight-position field. Alpha and numeric characters are allowed. Ignore special characters.
Diag-Indicator	24e	Normally, this field will contain combinations of the numerals 1, 2, 3, and 4. If a diagnosis code is coded, key the first four positions of the diagnosis code.
Billed-Charge	24f	Key numeric values as coded.
Units (Days)	24g	When decimals are coded, key only the data to the left of the decimal. (ex:1.5 = 1)
Family-Plan-IND-EPSDT	24h	If **Family Plan** indicator includes alpha character and number, key the number only. Ex: 1A, you would key in 1 only.
Rendering/Servicing ID Qualifier	24i (shaded)	Valid qualifiers of *1D*, *ZZ* and spaces will be accepted. If Block 24i is coded and 24j is not, the value in 24i should be keyed.
Rend/Serv/Taxonomy ID	24J (shaded)	Key this field only if Block 24i (shaded/clear) is coded with a qualifier of *1D* or *ZZ*. If not, enter out of the field. If Bock 24i is coded with *ZZ,* Alpha characters are allowed and will be flagged for operator to validate. If Block 24i is coded with *1D*, Alpha characters are not allowed and will be flagged for operator to validate. Data not falling within the validity check will require rekeying.
NPI Rendering/Servicing Provider	24J	Enter out of the field when nonnumeric characters such as alpha or special characters are coded. Data

CMS-1500		
Data Element Name	**Block #**	**Comments**
	(White)	not falling within the validity check of 10 digits will require rekeying.
Patient-Acct-Number	26	Ignore punctuation; only alpha and numeric characters will be allowed.
Total-Charges	28	This field is used to validate the values keyed in 24F.
Payment-Amount	29	Key numeric values as coded.
Balance Due	30	Key numeric values as coded.
Servicing Prov Zip Code	32	Ignore dashes.
Billing Provider Zip Code	33	Ignore dashes
NPI Billing Provider	33.a	Enter out of the field when nonnumeric characters such as alpha or special characters are coded. Data not falling within the validity check of 10 digits will require rekeying.
ID Qualifier	33b.1	Valid qualifiers of *1D*, *ZZ* or spaces will be accepted. These codes will precede the Billing/Taxonomy ID. Enter out of the field when blank.
Billing-Provider/Taxonomy	33b.2	Key this field only if Block 33b1 (shaded/clear) is coded with a qualifier of *1D* or *ZZ*. If not, enter out of the field. If Bock 33b1 is coded with *ZZ*, Alpha characters are allowed and will be flagged for operator to validate. If Block 33b1 is coded with *1D*, Alpha characters are not allowed and will be flagged for operator to validate. Data not falling within the validity check will require rekeying.
Notes:		
1. In the OCR process, all lines will be moved to the top so as to be consecutive		
2.The first line will be assigned a line number of 01, the second 02, etc.		
3. Detail lines can occur 6 times.		

UB04		
Data Element Name	**Box #**	**Keying Instructions**
ICN Number	ICN	Automatically populated. Not a keyed field.
Serv-Prov-Zip-Code	1	Do not capture dashes.
Patient-Acct-Number	3	Alpha and numeric characters are allowed. Special characters are invalid.
Medical-Record-Number	3B	Ignore punctuations. Alpha and numeric characters are valid.
Bill-Type	4	Key as coded.
Service-From-Date	6.1	This date must be entered in the MMDDYY (month, day, and year) format.
Service-Thru-Date	6.2	This date must be entered in the MMDDYY (month, day, and year) format.
Admission-Date	12	This date must be entered in the MMDDYY (month, day, and year) format.
Hour-Of-Admission	13	Key only numeric values.
Nature-Of-Admission	14	Key only numeric values.
Admission-Source	15	Key only numeric values
Hour-Of-Discharge	16	Key only numeric values
Discharge-Status	17	Key only numeric values
Condition-Code Occurs 11 Times.	18-28	Any data not falling within the valid entries will be flagged for operator intervention. Alpha and numeric characters are allowed.
Accident-State	29	Key only alpha characters.
Crossover Indicator	30	This is not a keyed field. When coded, with the word **Crossover**, the claim is processed as a Crossover claim using batch name **UX**.
Occurrence-Fld Occurs 8 Times.	31A-34B	
Occurrence-Code	31A-34B	Alpha and numeric characters are allowed
Occurrence-From-Date	31A-34B	This date must be entered in the MMDDYY (month, day, and year) format.
Occurrence-Span Occurs 4 Times.	35A-36B	
Occurrence-Span-Code	35A-36B	Alpha and numeric characters are allowed
Occur-Span-From-Date	35A-36B	This date must be entered in the MMDDYY (month, day, and year) format.

UB04		
Data Element Name	**Box #**	**Keying Instructions**
Occur-Span-Thru-Date	35A-36B	This date must be entered in the MMDDYY (month, day, and year) format.
Special Process Indicator (TDO/ECO)	37	Non display field.
Value-Seq-No Occurs 12 Times.		
Value-Code	39A-41D	Alpha and numeric characters are allowed.
Value-CD-Amount	39A-41D	Key data on the line that it is coded on.
Revenue-Data Occurs 115 Times.		
Revenue-Code	42	Only numeric values are allowed. If too long, key as much as you can. Revenue codes should only be keyed when there is a dollar amount in Block 47.
Revenue-HCPCS-Rate	44	This field is only keyed when Block 42 is coded with *0490* and Block 44 consists of values *10000 - 69999*. Any data not falling within the valid entries will be flagged for operator intervention
Revenue-Units	46	When decimals are coded, only key the data to the left of the decimal. (ex: 1.5 = 1)
Rev-Total-Charges	47	Key numeric values as coded.
Rev-Non-Cvrd-Charges	48	Key numeric values as coded.
Payer-ID	50	For Locator Box 50 (Payer), enter a value of *A*, *B*, or *C* to indicate the first line that names a Medicaid payer. If there are no Medicaid Payers, enter out of the field. A **Medicaid Payer** description can contain any of the following words or abbreviations: ▪ MEDICAID ▪ M'CAID ▪ Virginia Medical Assistance Program ▪ VMAP ▪ VMP ▪ TDO ▪ SLH ▪ DMAS ▪ Detention ▪ ECO.
Patient-Pay-Amount	54	Occur s three times. Do not key decimal points into this data entry field. Key numeric values as coded.

UB04		
Data Element Name	**Box #**	**Keying Instructions**
Ser-Provider-NPI	56	Enter out of the field when blank. Alpha characters are invalid. Data not falling within the 10-digit validity check will require rekeying. Note: Provider ID occurs three times - Key all three when coded.
Prov-Enrollee-Info Occurs 3 Times		
Ser-Provider-Number	57	Enter out of the field when blank. Alpha characters are invalid. Data not falling within the 7, 9 or 10 digit validity check will require rekeying.
Enrollee-ID	60	Occurs three times. Enter out of the field when non-numeric characters are coded.
PA-Number Occurs 3 Times. (Treatment Authorization Codes)	63	Enter out of the field when blank. Data not falling within the 9 or 11 digit validity check will require rekeying.
Former-ICN-No Occurs 3 Times.	64A, 64B, 64C	Within Locator Box 64, up to three Former ICN numbers may be entered on lines A, B, and C. Key all ICN numbers entered into Locator Box 64. Alpha and numeric characters are allowed. During the OCR process any numbers not read as 10 or 16 digits will be flagged for operator intervention.
Princ-Diag-Code	67	Do not key decimal points into this data entry field.
Princ-Diag-Code-POA	67 Shaded Area	Valid entries are blank, Y, N, U, W.
Secnd-Diag-Code	67A	Do not key decimal points into this data entry field.
Secnd-Diag-Code-POA	67A Shaded Area	Valid entries are blank, Y, N, U, W.
Third-Diag-Code	67B	Do not key decimal points into this data entry field.
Third-Diag-Code-POA	67B Shaded Area	Valid entries are blank, Y, N, U, W.
Fourth-Diag-Code	67C	Do not key decimal points into this data entry field.
Fourth-Diag-Code-POA	67C Shaded Area	Valid entries are blank, Y, N, U, W.
Fifth-Diag-Code	67D Shaded Area	Do not key decimal points into this data entry field.
Fifth-Diag-Code-POA	67D Shaded Area	Valid entries are blank, Y, N, U, W.

UB04		
Data Element Name	**Box #**	**Keying Instructions**
Sixth-Diag-Code	67E	Do not key decimal points into this data entry field.
Sixth-Diag-Code-POA	67E Shaded Area	Valid entries are blank, Y, N, U, W.
Seventh-Diag-Code	67F	Do not key decimal points into this data entry field.
Seventh-Diag-Code-POA	67F Shaded Area	Valid entries are blank, Y, N, U, W.
Eighth-Diag-Code	67G	Do not key decimal points into this data entry field.
Eighth-Diag-Code-POA	67G Shaded Area	Valid entries are blank, Y, N, U, W.
Ninth-Diag-Code	67H	Do not key decimal points into this data entry field.
Ninth-Diag-Code-POA	67H Shaded Area	Valid entries are blank, Y, N, U, W.
Diag-Code 10	67I	Do not key decimal points into this data entry field.
Diag-Code10-POA	67I Shaded Area	Valid entries are blank, Y, N, U, W.
Diag-Code11	67J	Do not key decimal points into this data entry field.
Diag-Code11-POA	67J Shaded Area	Valid entries are blank, Y, N, U, W.
Diag-Code12	67K	Do not key decimal points into this data entry field.
Diag-Code12-POA	67K Shaded Area	Valid entries are blank, Y, N, U, W.
Diag-Code13	67L	Do not key decimal points into this data entry field.
Diag-Code13-POA	67L Shaded Area	Valid entries are blank, Y, N, U, W.
Diag-Code14	67M	Do not key decimal points into this data entry field.
Diag-Code14-POA	67M Shaded Area	Valid entries are blank, Y, N, U, W.
Diag-Code15	67N	Do not key decimal points into this data entry field.
Diag-Code15-POA	67N Shaded Area	Valid entries are blank, Y, N, U, W.
Diag-Code16	67O	Do not key decimal points into this data entry field.
Diag-Code16-POA	67O Shaded Area	Valid entries are blank, Y, N, U, W.

UB04		
Data Element Name	**Box #**	**Keying Instructions**
Diag-Code17	67P	Do not key decimal points into this data entry field.
Diag-Code17-POA	67P Shaded Area	Valid entries are blank, Y, N, U, W.
Diag-Code18	67Q	Do not key decimal points into this data entry field.
Diag-Code18-POA	67Q Shaded Area	Valid entries are blank, Y, N, U, W.
Adjustment-Reason	68A	When more than one **ADJ** code is listed, key the first code.
Adm-Diag-Code	69	Do not key decimal points into this data entry field. Alpha and numeric characters are allowed.
Patient-Reason-Code(1)	70A	Do not key decimal points into this data entry field. Alpha and numeric characters are allowed.
Patient-Reason-Code(2)	70B	Do not key decimal points into this data entry field. Alpha and numeric characters are allowed.
Patient-Reason-Code(3)	70C	Do not key decimal points into this data entry field. Alpha and numeric characters are allowed.
Ext-Cause-Code	72A	Do not key decimal points into this data entry field. Alpha and numeric characters are allowed.
Ext-Cause-Code-POA	72A Shaded Area	Valid entries are blank, Y, N, U, W.
Ext-Cause-Code(2)	72B	Do not key decimal points into this data entry field. Alpha and numeric characters are allowed.
Ext-Cause-Code-POA(2)	72B Shaded Area	Valid entries are blank, Y, N, U, W.
Ext-Cause-Code(3)	72C	Do not key decimal points into this data entry field. Alpha and numeric characters are allowed.
Ext-Cause-Code-POA(3)	72C Shaded Area	Valid entries are blank, Y, N, U, W.
Princ-Proc_Code	74.1	Alpha/numeric data not falling within the valid entries will require rekeying.
Princ-Proc-Date	74.2	This date must be entered in the MMDDYY (month, day, and year) format.
Other1-Proc-Code	74A.1	Alpha/numeric data not falling within the valid entries will require rekeying.
Other1-Proc-Date	74A.2	This date must be entered in the MMDDYY (month,

UB04		
Data Element Name	**Box #**	**Keying Instructions**
		day, and year) format.
Other2-Proc-Code	74B.1	Alpha/numeric data not falling within the valid entries will require rekeying.
Other2-Proc-Date	74B.2	This date must be entered in the MMDDYY (month, day, and year) format.
Other3-Proc-Code	74C.1	Alpha/numeric data not falling within the valid entries will require rekeying
Other3-Proc-Date	74C.2	This date must be entered in the MMDDYY (month, day, and year) format.
Other4-Proc-Code	74D.1	Alpha/numeric data not falling within the valid entries will require rekeying
Other4-Proc-Date	74D.2	This date must be entered in the MMDDYY (month, day, and year) format.
Other5-Proc-Code	74E.1	Alpha/numeric data not falling within the valid entries will require rekeying
Other5-Proc-Date	74E.2	This date must be entered in the MMDDYY (month, day, and year) format.
Attn Dg-Phys-ID-NPI	76.1	Only numeric values are allowed.
Attndg-Phys-ID Qualifier	76.2	Field is not captured. (Non Display)
Attndg-Phys-ID	76.3	Enter out of the field when blank. Data not falling within the 7, 9 or 10 digit validity check will require rekeying.
Other1-Phys-ID-NPI	78.2	Only numeric values are allowed
Other1-Phys-ID Qualifier	78.3	Field is not captured. (Non Display)
Other1-Phys-ID	78.4	Enter out of the field when blank. Data not falling within the 7, 9 or 10 digit validity check will require rekeying.
Other2-Phys-ID-NPI	79.2	Only numeric values are allowed
Other1-Phys-ID Qualifier	79.3	Field is not captured. (Non Display)
Other2-Phys-ID	79.4	Enter out of the field when blank. Data not falling within the 7, 9 or 10 digit validity check will require rekeying.
Taxonomy Identifiera	81a1-81d1	Key only if Blocks 81a1-81d1 are coded with **B3**. If more than one B3 is coded, key the first coded block.

UB04		
Data Element Name	**Box #**	**Keying Instructions**
Service Provider Taxonomy	81A2-81D2	Alpha and numeric values are allowed. Ignore special characters.
Attachment/Remarks Indicator	80	If remarks are coded key a *1*. If no remarks are coded, key *2*.
NOTES:		
1. Up to 5 pages can be keyed as a multi-page claim.		
2. There is an edit on all date fields that will position you back to the beginning of the field if the keyed year is 2 years or greater than the current year.		

ADA 1999-2000		
Field Name	**Block #**	**Comments**
ICN		Automatically Populated - Not a keyed field .
Trans-Type	1	Key a *1* if **Dentist's pre-treatment estimate** is checked. Key a *2* if **Dentist's statement of actual services** is checked.
Preauthorization Number	2	Ignore Punctuation. Alpha and numeric characters are allowed.
Adjustment-Reason	12	Only numeric values are allowed.
Former ICN	13A	Valid entries are either 10 or 16 characters. Alpha characters are valid. Ignore special characters. Data not falling within the validity checks will require rekeying.
Patient-Acct-Number	13B	Alpha and numeric characters are allowed. Ignore punctuation.
Pat-Is-Spouse-To-Insr	17.1	Key a *1* if **Self** is checked within Locator Box 17. The export program will translate the value keyed to a **Y** in the correct position and put an **N** in each of the other positions.
Pat-Is-Spouse-To Insr	17.2	Key a *2* if **Spouse** is checked within Locator Box 17. See Above.
Pat-Is-Child-To-Insr	17.3	Key a *3* if **Child** is checked within Locator Box 17. See Above.
Pat-Is-Other-To-Insr	17.4	Key a *4* into this field if **Other** is checked within

ADA 1999-2000		
Field Name	**Block #**	**Comments**
		Locator Box 17. See Above.
Enrollee-ID (Patient ID)	19	If the value keyed is not valid, the cursor is positioned back to the beginning of the field; the field will be accepted when the same data has been keyed twice. When blank, key a zero and enter out of the field. If too long or too short, key as much as you can ignoring alpha characters.
Provider-Number	44	Enter out of the field when nonnumeric characters are coded. If too many digits are coded, key as much as you can. If the value keyed is not in the valid entries for this field, the data entry operator will be positioned back to the beginning of the field. The field will be accepted when the same data has been keyed twice.
Empl-Accident - Occupational Related	56	Key a *1* if the **No** column is checked and a *2* if the **Yes** column is checked.
Auto-Accident	57.1	If **Auto Accident** column is checked, key a *1*, otherwise leave blank.
Other-Accident	57.2	If **Other Accident** column is checked, key a *1*, otherwise leave blank.
Service-From-Date	59A	The date must be entered in the MMDDYY (month, day, and year) format.
Dental-Tooth-Code	59B	If the value keyed is not valid, the cursor is positioned back at the beginning of the field; the field will be accepted when the same data has been keyed twice.
Surface-Code Occurs 5 Times	59C	Valid entries for any position of this field are MODFLBI. Any other value will require the field to be rekeyed.
Procedure-Code	59E	Data not falling within the validity checks will require rekeying.
Units (QTY)	59F	This field is set up to skip; any value other than 1 will require the operator to back up to key into this field.
Billed-Charge	59H	Key numeric values as coded..
ADA-TPL	59I	This field is located under the heading **Admin. Use**

ADA 1999-2000		
Field Name	**Block #**	**Comments**
		Only. Key when coded.
Total-Billed Charges	59J	The data keyed in this field will be compared to the data keyed in Block 59H. If the amounts do not balance, all fields referenced will be flagged for review in the Remove Flags step. If blank key a zero and enter. Key numeric values as coded.
Remarks/Attachment Indicator	61	If remarks are coded, key a *1*. If not, key a *2*.
Request-Date	62C	This date must be entered in the MMDDYY (month, day, and year) format.
Serv-Prov-Zipcode	66	Do not key dashes (-).
Note:		
If more than 8 lines are coded, reject the document.		

ADA 2002		
Field Name	**Block #**	**Comments**
ICN		Automatically Populated - Not a keyed field.
Type of Transaction	1	Key a *1* into this field if **Statement of Actual Services** is checked. Key a *2* into this field if **Request for Predetermination/Preauthorization** is checked.
Preauthorization Number	2	Ignore Punctuation. Alpha and numeric characters are allowed.
Enrollee ID (Patient ID)	15	If the value keyed is not valid, the cursor is positioned back to the beginning of the field; the field will be accepted when the same data has been keyed twice. When blank, key a zero and enter out of the field. If too long or too short, key as much as you can ignoring alpha characters.
Pat-Is-Self-To-Insr	18.1	Key a *Y* into this field if **Self** is checked within Locator Box 18. The data for Block 18 will be keyed as a single 1 position field. The data entry operator will key a *1* for Self, *2* for Dependent Child, *3* for Spouse, or *4* for Other. The export program will translate the value keyed to a **Y** in the correct position and put an **N** in each of the other positions.

ADA 2002		
Field Name	**Block #**	**Comments**
Pat-Is-Spouse-To-Insr	18.2	Key a *Y* into this field if **Spouse** is checked within Locator Box 18. See Above.
Pat-Is-Child-To-Insr	18.3	Key a *Y* into this field if **Dependent Child** is checked within Locator Box 18. See Above.
Pat-Is-Other-To-Insr	18.4	Key a *Y* into this field if **Other** is checked within Locator Box 18. See Above.
ADJ RSN	21	Only numeric values are allowed.
Former ICN	23A	Valid entries are either 10 or 16 characters. Alpha characters are valid. Ignore special characters. Data not falling within the validity checks will require rekeying.
Patient Account Number	23B	Alpha and numeric characters are allowed. Ignore punctuation.
Service From Date	24	This date must be entered in the MMDDYY (month, day, and year) format.
Tooth Code	27	If the value keyed is not valid, the cursor is positioned back at the beginning of the field; the field will be accepted when the same data has been keyed twice.
Surface Code (Occurs 5 Times)	28	The valid entries for any position of this field are MODFLBI. Any other value entered will require the field to be rekeyed.
Princ-Procedure-Code	29	Data not falling within the validity checks will require rekeying.
Billed Charge	31	Key numeric values as coded.
Total Billed Charge	33	The data keyed in this field will be compared to the data keyed in Block 31. If the amounts do not balance, all fields referenced will be flagged for review in the **Remove Flags** step If blank key a zero and enter. Key numeric values as coded.
Remarks/Attachment Indicator	35	If remarks are coded, key a *1* If not, Key a *2*.
Occupation Related	45.1	Key a *1* into this field if **Occupational illness/injury** is checked. Leave blank if not checked.
Auto Accident	45.2	Key a *1* into this field if **Auto Accident** is checked. Leave blank if not checked.

ADA 2002		
Field Name	**Block #**	**Comments**
Other Accident	45.3	Key a *1* into this field if **Other Accident** is checked. Leave blank if not checked.
Request Date	53B	This date must be entered in the MMDDYY (month, day, and year) format.
Provider ID	54	Key a zero and enter out of the field when non numeric characters are coded. If the value keyed is not in the valid entries for this field, the data entry operator will be positioned back at the beginning of the field. The field will be accepted when the same data has been keyed twice. If too many digits are coded, key as much as you can.
Serv-Prov-Zipcode	56*	Do not key dashes (-).
Note:		
If more than 10 lines are coded, reject the document.		

ADA 1994		
Data Element Name	**Block #**	**Comments**
ICN-Number	ICN	Automatically Populated - Not a keyed field.
Provider-Number	1	Enter out of the field when nonnumeric characters are coded. If too many digits are coded, key as much as you can. If the value keyed is not in the valid entries for this field, the data entry operator will be positioned back to the beginning of the field. The field will be accepted when the same data has been keyed twice.
PA-Number (Preauthorization Number)	2	The PA Number is above the Patient ID (Enrollee ID) block. Given the close proximity of information in Locator Box 2, there is the strong possibility that entries will not be aligned with their respective header lines. If there are two values entered into Locator Box 2, the first value is to be entered as the PA Number. The second value is to be entered as the Patient ID (Enrollee ID). Alpha and numeric characters are allowed. Ignore punctuation.
Enrollee-ID (Patient ID)	2	The Patient ID (Enrollee ID) Is located in Locator Box 2 under the PA-Number. Given the close

ADA 1994		
Data Element Name	**Block #**	**Comments**
		proximity of information in Locator Box 2, there is the strong possibility that entries will not be aligned with their respective header lines. If there are two values entered into Locator Box 2, the first value is to be entered as the PA Number. The second value is to be entered as the Enrollee ID. If only one value is entered into Locator Box 2, that one value is to be entered as the Patient ID (Enrollee-ID). If the value keyed is not valid, the cursor is positioned back at the beginning of the field; the field will be accepted when the same data has been keyed twice. When blank, key a zero and enter out of the field. If too long or too short, key as much as you can ignoring alpha characters.
Trans-Type	3	Valid entries will be 000, 180, 181, 182, and 184. Any value keyed which is not one of the valid entries will require rekeying by the entry operator.
Pat-Is-Self-To-Insr	5.1	Key a *1* if **Self** is checked within Locator Box 5. The export program will translate the value keyed to a **Y** in the correct position and put an **N** in each of the other positions.
Pat-Is-Spouse-To-Insr	5.2	Key a *3* if **Spouse** is checked within Locator Box 5. See Above.
Pat-Is-Child-To-Insr	5.3	Key a *2* if **Dependent Child** is checked within Locator Box 5. See Above.
Pat-Is-Other-To-Insr	5.4	Key a *4* if **Other** is checked within Locator Box 5. See Above.
Adjustment-Reason	7	Only numeric values are allowed.
Former-ICN-No	8	Valid entries are either 10 or 16 characters. Alpha characters are valid. Ignore special characters. Data not falling within the validity checks will require rekeying.
Patient-Acct-Number	10	Punctuation will be ignored
Empl-Accident – Occupational Illness	30	Key a *1* if the **No** column is checked and a *2* if the **Yes** column is checked.
Auto-Accident	31	Key a *1* if the **No** column is checked and a *2* if the **Yes** column is checked.

ADA 1994		
Data Element Name	**Block #**	**Comments**
Other- Accident	32	Key a *1* if the **No** column is checked and a *2* if the **Yes** column is checked.
Dental-Tooth-Code	37A	If the value keyed is not valid, the cursor is positioned back at the beginning of the field; the field will be accepted when the same data has been keyed twice.
Dental-Surface-Code Occurs 5 Times	37B	Valid entries for any position of this field are MODFLBI. Any other value will require the field to be rekeyed. Numeric values are not allowed.
Service-From-Date	37D	This date must be entered in the MMDDYY (month, day, and year) format.
Units (Proc #)	37E	This field is set up to skip; any value other than 1 will require the operator to back up to key into this field.
Procedure-Code	37F	Data not falling within the validity checks will require rekeying.
Billed-Charge	37G	Key numeric values as coded..
De-Claim-ADA-TPL	37H	Key numeric values as coded.
Total-Billed-Charges	41	The data keyed in this field will be compared to the data keyed in Block 37G. If the amounts do not balance, all fields referenced will be flagged for review in the Remove Flags step. If blank key a zero and enter. Key numeric values as coded.
Remarks/Attachment Indicator	38	If remarks are coded, key a *1* If not, key a *2*
Serv-Prov-Zipcode	40*	Do not key dashes (-).
Note:		
If more than 15 lines are coded, reject the document.		

Claim Attachment Number		
Data Element Name	**Block#**	**Comments**
Patient Account Number	1A	Ignore spaces, punctuations and special characters.
Date of Service	1B	
Sequence Number	1C	